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Individuals' Experiences of Adolescent Self-Harm

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This thesis has been submitted as part of the fulfilment of requirements for the degree of
Doctorate in Clinical Psychology

Coventry University, Faculty of Health and Life Sciences
University of Warwick, Department of Psychology

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List of Abbreviations

MHF	Mental Health Foundation
NICE	National Institute of Clinical Excellence
UK	United Kingdom
PRISMA	Preferred Reporting Items for Systematic Review and Meta-Analysis
IPA	Interpretive Phenomenological Analysis
CASP	Critical Appraisal Skills Programme
ENTREQ	Enhancing Transparency in Reporting the Synthesis of Qualitative Research
CAMHS	Child and Adolescent Mental Health Services
RCP	Royal College of Psychiatrists
NHS	National Health Service
MAPPG	Mindfulness All-Party Parliamentary Group
SSIs	Semi-Structured Interviews
BPS	British Psychological Society
WHO	World Health Organisation
HRA	Health Research Authority
NMC	Nursing and Midwifery Council
CFT	Compassion Focussed Therapy

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- A** Child and Adolescence Mental Health Journal Author Guidelines
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- F** Author Guidelines for the Journal of Clinical Nursing
- G** Participant Information Sheet
- H** Coventry University Ethical Approval for Chapter Two Empirical
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- I** HRA Ethical Approval HRA Ethical Approval for Chapter Two
Empirical Paper
- J** Participant Information Sheet
- K** Informed Consent Form
- L** Participant Debrief
- M** Interview Schedule
- N** Example Coding
- O** Photos of Theme Clustering Process

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Firstly, I would like to convey my admiration and thanks to all of the nurses who gave up their time to participate in this research, which I hope can be used to help others. I really appreciated your honesty and passion, which inspired me and enhanced my passion for working with adolescents.

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Declaration

This thesis has been submitted for the Clinical Psychology Doctorate at the Universities of Coventry and Warwick. The work presented has been composed by myself and has not been submitted for any other qualification or to any other institution. This thesis is an original piece of my own work, which was undertaken with the academic and clinical supervision of Dr Sarah Simmonds (Coventry University), Dr Claudie Fox (University of Warwick) and Dr Victoria Hill (Coventry and Warwickshire Partnership NHS Trust). The literature review was written for submission to the *Child and Adolescent Mental Health Journal*, while the empirical paper was written in preparation for the *Journal of Clinical Nursing*. Emergent findings from the empirical paper will be presented within the West Midlands' NHS Trusts meetings and conferences, and as a poster presentation at the University of Warwick Postgraduate Research conference and the Coventry Postgraduate conference.

Summary

Adolescent self-harm has been recognised as an international healthcare concern. Given the challenge that self-harm presents for adolescents and professionals, this thesis aimed to provide a more in-depth understanding of the experiences of adolescents who self-harm and the professionals working with them.

Chapter one is a systematic review investigating qualitative research exploring adolescents' experiences of self-harm. Twelve studies were identified through electronic database and manual searches. Building on the individual studies, the Thematic Synthesis identified the paradoxical nature of self-harm: *Control* (self-harming to gain control yet experiencing self-harm as uncontrollable), *Purpose* (self-harm as a form of self-preservation or self-punishment), and *Others* (stigmatising and helpful responses). Policy and clinical implications concerning increased education regarding self-harm and the paradoxes are discussed. Limitations and research recommendations are also considered.

Chapter two is a qualitative research study that used Interpretative Phenomenological Analysis to explore the lived experiences of nurses who work with adolescents who self-harm within community Child and Adolescent Mental Health Services (CAMHS). Ten nurses participated in semi-structured interviews. The analysis led to the identification of two superordinate themes, each with two subthemes. The findings suggest that CAMHS nurses experience a range of personal and professional conflicts in their work with adolescents who self-harm, and the systems around them. All nurses described a process of development, learning to manage the conflicts and emotions they experience, as well as gaining confidence and understanding through experience. Policy and clinical implications are considered, including supervision and training to understand and manage these conflicts. Limitations and research recommendations are also discussed.

Chapter three is a reflective account of the author's experience of conducting this research. The author discusses the value of reflective practice, and reflexivity within the research process, and their position as a researcher and 'partial insider'. The author reflects on their experiences and personal and professional development, and how these paralleled the experiences described by the research participants.

Overall word count: 19,823 (at submission; excluding abstracts, tables, figures and references)

Chapter 1: Systematic Literature Review

Experiences of Self-Harm in Adolescence: A Thematic Synthesis of Qualitative Research

*Written in preparation for submission to the Child and Adolescent Mental Health
Journal (See Appendix A for author guidelines)*

Overall chapter word count (at submission; excluding tables, figures and references):

7974

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1.0. Abstract

Background: Self-harm in adolescence has been recognised as a major international healthcare concern, with rates increasing and higher than all other age groups. While there has been a move towards exploring adolescents' experiences using qualitative approaches, there appears to be a lack of attempt to draw together this evidence. The subsequent aim of this qualitative synthesis was to critically evaluate qualitative studies that have explored adolescents' experiences of self-harm, to address the question: What are adolescents' experiences of self-harm? **Method:** A comprehensive systematic search of qualitative literature investigating adolescents' experiences of self-harm was carried out July- September 2018, within Academic Search Complete, PsycINFO, The Allied and Complementary Medicine Database, PsychARTICLES, MEDLINE and CINAHL databases. Of the 4039 studies identified, 12 articles met the review inclusion criteria. All 12 articles were quality assessed using the Critical Appraisal Skills Programme framework. **Results:** Thematic Synthesis highlighted three paradoxical themes that were common in adolescents' experiences: 1) *Control*, adolescents' paradoxical experiences of self-harming to gain control yet experiencing self-harm as uncontrollable, 2) *Purpose*, another paradox regarding the purpose of self-harm as a form of self-preservation or self-punishment, and 3) *Others*, the paradox of stigmatising responses leading to an avoidance of disclosure, and finding support helpful. **Conclusions:** Subsequent policy and clinical implications are discussed, including increased awareness and education regarding self-harm and the paradoxes associated with it. Limitations and research recommendations are also considered.

Word count: 231 words

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Key Practitioner Message:

- A synthesis of the growing qualitative research exploring adolescent self-harm is required.
- This synthesis builds on the individual articles by demonstrating adolescents' paradoxical experiences of self-harm, which it would be helpful for professionals working with these adolescents to consider.

Keywords: adolescent, self-harm, self-injury, qualitative research, review.

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1.1. Introduction

1.1.1. Review Subject and Significance

The aim of this systematic review is to explore experiences of self-harm in adolescence. Self-harm is a complex and poorly understood phenomenon (Holley, 2016), thus definitions vary greatly (Madge et al., 2008). The self-harm definition used in this review is “a nonsuicidal behaviour where an individual deliberately causes harm to themselves, usually as a way to cope with difficult thoughts or emotions” (adapted from Lesniak (2010) and the Mental Health Foundation (MHF; 2019)). Self-harm encompasses a wide variety of behaviours such as cutting, burning and overdosing (Mitten et al., 2016; MHF, 2006). Diverse terminology has consequently been used in the literature, including deliberate self-harm, parasuicide and non-suicidal self-injury, as well as more specific terms such as self-poisoning and self-mutilation (Fox, 2011). The National Institute for Health and Care Excellence (NICE; 2004) recommended the use of the term self-harm, which is adopted in this review in order to encompass the wide variety of behaviours seen, and avoid confusion or offensive labels (Levander, 2005).

Self-harm usually begins during adolescence, with an average age of onset of 13 to 16 years (Klonsky, 2011). In this review, adolescence is defined as the developmental stage between childhood and adulthood (Schlegel & Hewlett, 2011), within which significant social, biological and cognitive changes take place (Dahl, 2004). Subsequently, adolescents experience increased difficulties with emotional control and impulsivity (Groschwitz & Plener, 2012), which are associated with self-harm (You & Leung, 2012).

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Self-harm in adolescence has been recognised as a major international healthcare concern, with rates during adolescence increasing, and higher than all other age groups (Greydanus & Shek, 2009; McManus et al., 2016). Current adolescent prevalence estimates range from 15%-20% (Morey et al., 2016; Kidger et al., 2012), with a 68% increase in UK hospital self-harm presentations in adolescent females between 2011 and 2014 (Morgan et al., 2017). However, these figures are likely to only represent the 'tip of the iceberg' (Ystgaard et al., 2009), as less than 15% of adolescents who self-harm present to healthcare services (Hawton et al., 2009). Self-harm is therefore a cause for concern among clinicians, parents, practitioners, researchers and society (Nock, 2010; Mitten et al., 2016).

Adolescent self-harm has been associated with a range of physical, psychological and social impacts (Mitten et al., 2016). Whilst the form and severity varies, self-harm generally results in some form of physical harm (Nock, 2010). Additionally, adolescents who self-harm are at increased risk of difficult emotional experiences and mental health difficulties, including anxiety and depression (Baetens et al., 2012; Mars et al., 2014). Furthermore, self-harm has been identified as the strongest known risk factor for suicide (Cooper et al., 2005), with adolescents who self-harm being 17 times more likely to die by suicide than adolescents who do not self-harm (Morgan et al., 2017). It is therefore important to recognise that differentiating suicidal and self-harm behaviours can be challenging (Gulbas et al., 2015).

The English National Suicide Prevention Strategy (Department of Health, 2015) requested more research concerning self-harm. This review subsequently aims to

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facilitate a greater understanding of adolescent self-harm to increase professionals' confidence in engaging adolescents who self-harm and subsequently result in the implementation of better quality care for such young people (Abrams & Gordon, 2003; NICE, 2004). Additionally, it is hoped that synthesising the existing qualitative evidence will enable the consideration of multiple perspectives or contradictory viewpoints, and facilitate an understanding that goes beyond the primary findings (Carroll, 2017).

1.1.2. Previous Research

In reviewing the self-harm literature, two relevant qualitative meta-syntheses were identified. Lachal et al. (2015) completed a meta-synthesis of 44 studies investigating youth, parents, and healthcare professionals' perspectives of youth suicidal behaviours, which were published from 1990 to May 2014. Using thematic synthesis the authors identified themes relating to the individual burden and suffering related to suicide attempts, the importance of relationships with others, and the impact of societal acceptance or rejection. However, the exploration of suicidal behaviours cannot be extrapolated to people who self-harm (Muehlenkamp, 2005).

Addressing this criticism, Lindgren, Svedin and Werkö (2017) synthesised 11 qualitative studies exploring experiences of professional care among people up to 60 years of age who self-harm, published between 1995 and February 2015. Using the Swedish Agency for Health Technology Assessment and Assessment of Social Services methodology (SBU, 2014), the authors found participants described the importance of good quality caring relationships and tailored care. However, Lindgren et al. (2017) also

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concluded that the study failed to address the gaps in knowledge regarding experiences of adolescents, so there is a need for more research specifically exploring the experiences of adolescents who self-harm. In summary, no reviews of qualitative studies exploring adolescents' experiences of self-harm in general were identified.

1.1.3. Rationale and Aims

The previous reviews have important limitations. Firstly, both of the previous reviews were limited by broad participant samples, as neither focussed specifically on young people. The inclusion of children, adolescents and adults in Lindgren et al.'s (2017) study reduces the comparability of the studies and the strength of the findings, as adolescents who self-harm have been found to have specific needs that are different to that of adults (Taylor et al., 2009), thus reviews specifically exploring adolescents would be beneficial. Furthermore, the inclusion of parent and professional reports in Lachal et al.'s (2015) review limits the findings, as adolescents' perspectives are often misunderstood and invalidated when assessed through other respondents (Adams, Rodham, & Gavin, 2005; Hurry, Aggleton & Warwick, 2000). Finally, both studies failed to explore adolescents' experiences of self-harm more generally, as Lachal et al. (2015) explored suicidal behaviours, whilst Lindgren et al. (2017) only explored experiences of care. Overall, there appears to be a lack of synthesis of the available qualitative evidence regarding adolescents' experiences of self-harm (Lindgren et al., 2017).

The current review will overcome these limitations by critically evaluating qualitative studies that have explored adolescents' experiences of self-harm. This

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systematic review will address the question: *What are adolescents' experiences of self-harm?*

1.2. Method

1.2.1. Systematic Literature Search

A comprehensive systematic search of qualitative literature investigating adolescents' experiences of self-harm published in 2003-2018 was carried out between July 2018 and September 2018. Ethical approval for this review was granted by The University of Coventry Ethics Committee (Appendix B). The psychology, medical and nursing databases deemed most relevant, and subsequently included, were Academic Search Complete, PsycINFO, The Allied and Complementary Medicine Database, PsychARTICLES, MEDLINE and CINAHL. Additional searches were then carried out using Google Scholar, manual bibliographic searching, and by searching specific journals, such as the Journal of Child & Adolescent Mental Health, to reduce database biases (Schlosser, Wendt & Sigafos, 2007).

Table 1.1 presents an overview of the key search terms used to identify relevant literature. The Boolean search strategy included Adolescent AND Self-harm AND Experiences search terms, which were searched for within the article titles and abstracts. Due to the lack of consensus on the definition of self-harm (Ougrin, Ng & Zundel, 2009), a range of synonyms for self-harm were used to capture all relevant articles. Furthermore, multiple synonyms were used for Adolescent and Experiences.

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Table 1.1. *Search Terms and Boolean Operators Used to Capture All the Relevant Articles*

	Main Terms	Synonyms	Location
Population	Adolescent	boy or girl or women or men or teenagers or adolesc* OR 'young adult*' OR 'young pe*' OR people	Title Abstract ^a
Context	Experiences	Experience* OR perception* OR views	Title Abstract ^a
Outcome	Self-harm	'self-harm' OR 'self mutilat*' OR 'self injury' OR 'self harm' OR suicidal OR NSSI OR 'self cut*' OR 'self poison*' OR overdose	Title Abstract ^a

Note. These terms are organised using the Population, Context, Outcome (PCO) framework (Butler, Hall & Copnell, 2016).

^aInitial searches included full text, but results were too large due to replications and irrelevant studies.

1.2.2. Inclusion and Exclusion Criteria

The extracted article titles and abstracts were initially screened and retained for the review if they: (a) were peer-reviewed articles, (b) written in the English Language, (c) described a qualitative study, (d) explored adolescent experiences and (e) the full text was accessible. Following the initial screening, full text articles were obtained, screened and assessed for eligibility for the review according to the inclusion and exclusion criteria presented in Table 1.2.

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Table 1.2. *Inclusion and Exclusion Criteria Used to Screen the Extracted Studies*

Criteria	Include	Exclude
Participants	Adolescents (age 12-17) or Adults recalling self-harm experiences from adolescence ^a Any gender or ethnicity	Experiences of self-harm in childhood (younger than 12) or only in adulthood (older than 17)
Study Designs	Studies utilising a solely qualitative design (interviews, focus groups, open-ended questionnaires)	Quantitative designs, or mixed methods designs including qualitative and quantitative data (questionnaires or surveys with closed questions)
Focus (self-harm)	Findings regarding current or previous self-harm and suicidal behaviour, or self-harm only	Only suicidal behaviour, no self-harm
Focus (experiences)	Experiences of self-harm, and related issues (such as care provided and stigma)	Not experiences (such as attitudes or opinions)

^aIn the relevant literature, the upper age limit utilised to define adolescence has varied from 17 to 25 years (Hawton, Saunders & O'Connor, 2012). As a result, some of the papers presented include individuals older than 17 years, reflecting on their experiences in adolescence.

Studies were included if participants were: 1) male or female adolescents, or adults retrospectively talking about experiences in their adolescence, 2) with a history of, or current self-harm. Studies utilising a solely qualitative design were included. No limits were placed on the form of qualitative design (longitudinal, cross-sectional, prospective or retrospective), the sample size, recruitment method or method of data collection. Studies were included for review if they explored experiences of self-harm, and related issues, such as experiences of care and stigma regarding self-harm.

While studies investigating clients with self-harm, or both self-harm and suicidal behaviour were included, research that looked at only participants with suicidal behaviour were excluded as the review aimed to investigate experiences of self-harm. Quantitative or Mixed Method studies, and studies that explored adult (>17) or child (<12) experiences, or did not explore experiences were also excluded.

1.2.3. Classification of Studies

The search strategy and selection process are documented by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Figure 1.1), which has been used in previous qualitative syntheses (Ring et al., 2011). In total 4024 records were initially identified via the database searches, and a further 15 were identified through other sources (Google Scholar and reference lists). Of the 4039 studies identified, 2887 were duplicates. During a manual review of the title and abstracts of the 1152 subsequent articles, a further 1118 studies were excluded due to not meeting the criteria outlined above. Finally, a review of the full texts of the remaining eligible 34 articles was conducted, and a further 22 were excluded due to not being peer-reviewed (1), investigating only suicidal behaviour (5) or experiences in adulthood (10), and failing to investigate experiences (6). This resulted in 12 relevant articles that met the inclusion criteria for the review. While there has been debate regarding the number of studies that need to be included within a synthesis of qualitative studies, 8-13 studies are usually included, to provide a balance between having enough studies to establish depth of insight into the research question, without hindering the data analysis process with too many studies (Ring et al., 2011). In sum, a thorough search of the literature resulted in 12 qualitative studies that met the inclusion criteria and were subsequently retained for quality assessment and analysis within the systematic review.

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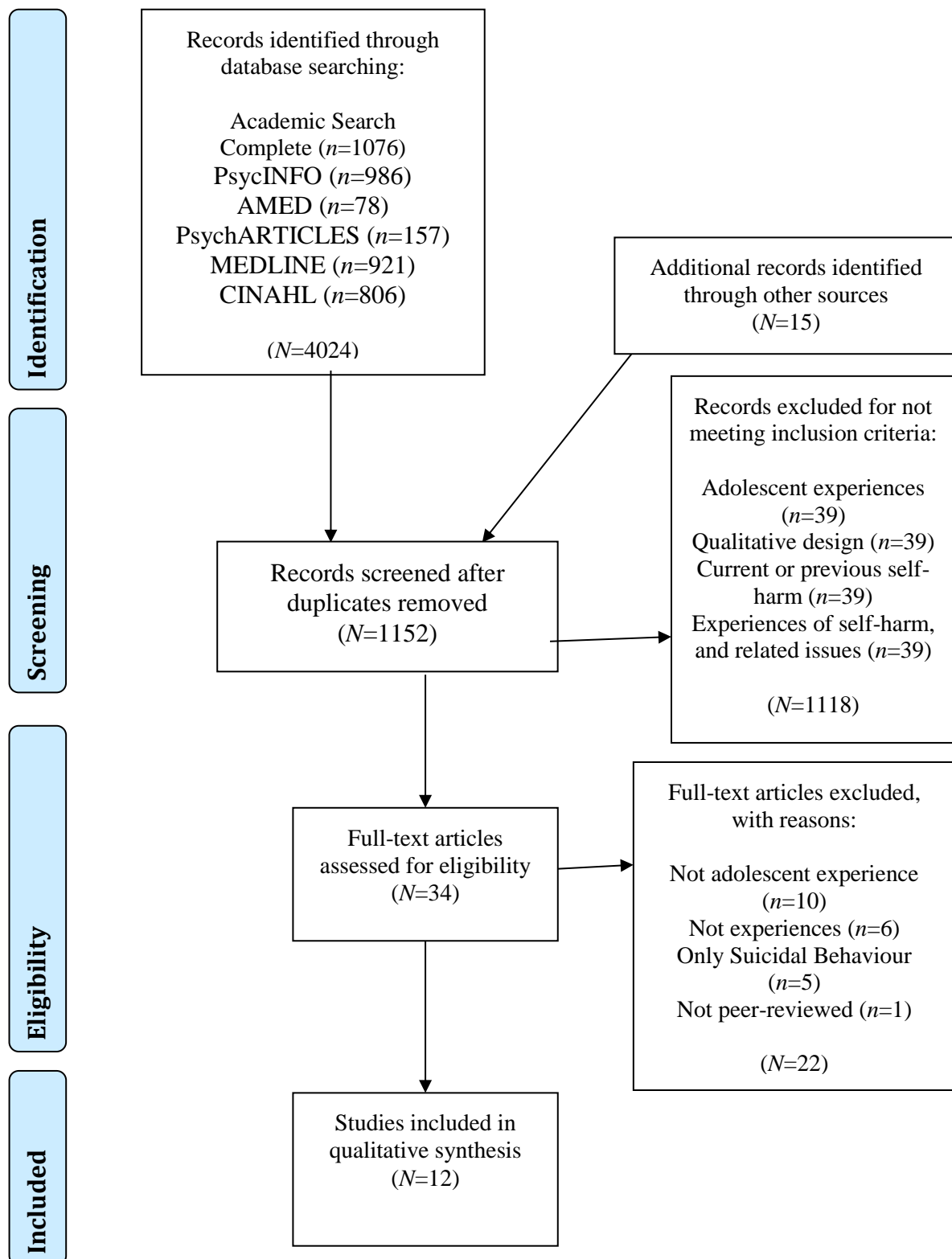


Figure 1.1. A PRISMA flow diagram to show the review process (Moher et al., 2009).

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1.2.4. Quality Assessment

Many authors have questioned the appropriateness of using quality rating frameworks in qualitative reviews (Hammersley, 2007; Kuper, Lingard & Levinson, 2008). It has been argued that appraising qualitative studies is greatly impacted by journal requirements, thus the quality rating is based more on the report quality and journal requirements than the actual study procedure (Atkins et al., 2008; Sandelowski & Barroso, 2002). Additionally, there is a lack of consensus regarding the most appropriate quality assessment framework for qualitative studies in health research (Katrak et al., 2004; Spencer et al., 2003). Nonetheless, a growing number of researchers are choosing to utilise quality assessments to facilitate the systematic and critical review of studies in meta-syntheses (Bettany-Saltikov, 2012; Butler, Hall & Copnell, 2016; Hannes & Macaitis, 2012; Lachal et al., 2017), with the aim of ascertaining the value and integrity of the findings (Thomas & Harden, 2008; Tong et al., 2012) and enabling a deeper understanding of their content (Ring, et al., 2011).

The articles were therefore assessed using the Critical Appraisal Skills Programme (CASP; 2013) quality assessment framework (see Appendix C), which is the most frequently used qualitative quality assessment tool (Hannes & Macaitis, 2012), and is recommended by the Cochrane Collaboration (Noyes et al., 2015). The tool assesses all the principles and assumptions underpinning qualitative research (Tong et al., 2012), and has been widely utilised for medical meta-syntheses, including a recent review in a similar subject area (e.g. Lachal et al., 2015). All 12 studies were scored against the 10-quality criterion. Consistent with previous research (Boeije, van Wesel &

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Alisic, 2011; Lachal et al., 2015), studies were rated as 0 (*criterion not met*), 1 (*criterion partially met*) or 2 (*criterion fully met*) for each criterion, leading to a final total score out of 20.

There is limited empirical evidence or consistency regarding exclusion decisions and cut-offs in qualitative syntheses (Popay, 2005; Walsh & Downe, 2006). Nonetheless, quality ratings can be used to establish study weightings, so that poorer quality studies contribute less to the synthesis (Bondas & Hall, 2007; Boeije et al., 2011). Consistent with previous research (Lachal et al., 2015), the framework was therefore used to facilitate the identification of the strengths and weaknesses of articles and their relative quality and weight within the synthesis, rather than to exclude studies. To enhance the confirmability of the analysis, the results are included in Appendix C.

1.2.4.1. Reliability of quality.

To enhance the quality assessment reliability, inter-rater reliability tests were carried out with all articles (See Table 1.3 for Kappa reliability coefficients). Altman (1999) proposed that Kappa coefficients of .80 and above indicate *strong agreement* (reliability), .60 to .79 represents *moderate agreement*, and values below .60 represent *poor agreement*. Based on this, all articles demonstrated moderate to strong inter-rater reliability, with a Kappa coefficient range from .62 to 1.00, and mean of .88 (see Appendix D). Discrepant ratings generally resulted from unfamiliarity with the topic area and were discussed to reach 100% agreement.

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1.2.4.2. Summary of quality assessment.

Overall, the quality of the studies ranged from 13/20 (65%) to 20/20 (100%), with credible authors, clear rationale and aims, appropriate analyses and generally comprehensive discussions. Limited ethical considerations and reflexivity were weaknesses of many of the studies. However, these issues were likely a consequence of editorial constraints, due to maximum word lengths being based on the presentation of quantitative data, and subsequently rather restrictive for qualitative research (Atkins et al., 2008). The quality assessment process also led to the identification of potential biases and limitations that should be acknowledged when considering the results of the review. These will be explored in the subsequent results section.

1.3. Results

1.3.1. Characteristics of the Literature

As shown in Table 1.3, the studies were all carried out within the past 15 years by credible authors (Psychologists, Senior Researchers and Professors), in various locations. Six studies used sample populations in the UK, and six were conducted outside the UK, recruiting from Canada (Mitten et al., 2016), Finland (Rissanen et al., 2008; Rissanen et al., 2009), South Africa (Bheamadu et al., 2012) and America (Lesnaik, 2010; Moyer & Nelson, 2007).

Eleven studies included 6-73 participants, who were either self-harming adolescents aged 12-17, or young adults aged 18-22 reflecting on their self-harm experiences in adolescence. Harvey and Brown (2012) were unable to report the number

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or ages of participants, due to their anonymous online data collection method.

Five of the studies centred on adolescents' experiences of self-harm (Bheamadu, Fritz, & Pillay, 2012; Harvey & Brown, 2012; Lesniak, 2010; Rissanen, Kylma & Laukkanen, 2008; Wadman et al. 2017a), and four explored experiences and perceptions of disclosure, stigma, help and care (Klineberg et al., 2013; McAndrew & Warne, 2014; Mitten et al., 2016; Rissanen, Kylma & Laukkanen, 2009). The other three focused on personal and interpersonal processes involved in self-harm, the meaning of self-harm, and reasons for self-harm repetition and maintenance (Crouch & Wright, 2004; Moyer & Nelson, 2007; Wadman et al., 2017b). Given the review question, any findings regarding young adults' experiences of self-harm, experiences of suicidal behaviour or adolescents' hopes or views, were discarded from the analysis.

The majority of the studies (10) conducted one-to-one semi-structured interviews to collect data, with three studies using triangulation by gathering further information from personal writings (Bheamadu et al., 2012; Rissanen et al., 2009) and observations (Crouch & Wright, 2004). The final two studies collected personal writings by analysing online messages on a forum (Harvey & Brown, 2012) and emails written to the researchers (Rissanen et al., 2008).

All 12 adopted solely qualitative methodologies, with various approaches to data analysis: four studies (Crouch & Wright, 2004; McAndrew & Warne, 2014; Wadman et al., 2017a; Wadman et al., 2017b) utilised Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003), while three studies (Mitten et al., 2016; Rissanen et al.,

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2008; Rissanen et al., 2009) used Content Analysis (Hsieh & Shannon, 2005).

Additionally, Bheamadu et al. (2012) employed Thematic Analysis (Braun & Clarke, 2006), Moyer and Nelson (2007) utilised Constant Comparison (Schwandt, 1997), Klineberg et al. (2013) employed a Framework approach (Ritchie & Lewis, 2003), Harvey and Brown (2012) Identified statistical keywords and key themes (Baker, 2006), and Lesnaik (2010) used the Giorgi method (Giorgi, 1997).

A number of limitations were considered when drawing conclusions from the studies. Firstly, the strength of the conclusions varied due to the difference in participant numbers, data collection methods and data analysis methods used. Additionally, samples lacked homogeneity due to differences in the type of self-harm and the ethnicity, age and gender of the adolescents. The samples were also biased due to the majority of participants being female.

Given the nature of the topic discussed, ethical issues such as informed consent, protection from harm and debriefing were particularly important. Unfortunately, only five studies reported a detailed consideration of ethical issues (Crouch & Wright, 2004; McAndrew & Warne, 2014; Mitten et al., 2016; Wadman et al., 2017a; Wadman et al., 2017b). The rest of the studies only demonstrated partial consideration of ethical issues, briefly reporting that informed consent was sought and gained. Nonetheless, all studies were granted ethical approval, so it is likely that additional ethical issues were considered, but not reported due to word limits.

Moreover, the validity of the findings of the majority of studies was also of

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concern, due to a lack of reflexivity. Whilst the majority utilised confirmation by a second researcher or independent researcher, only Lesniak (2010), Mitten et al. (2016) and Moyer and Nelson (2007) utilised respondent validation, to evaluate the accuracy of their themes, and only Lesniak (2010), Moyer and Nelson (2007), Wadman et al. (2017a) and Wadman et al. (2017b) demonstrated reflexivity through the consideration of their own biases and the use of audit trails and reflective logs. Nonetheless, most studies had good confirmability, due to the inclusion of direct quotes within their findings.

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Table 1.3. *Characteristics of the Research Studies*

Author, Date, Location and Quality Rating (Kappa Coefficient)	Study Aims	Sampling Method* and Sample Characteristics	Method(s) of Data Collection	Method of Data Analysis	Summary of Key Findings
Wadman et al. 2017a (UK) <i>QR</i> =20 (<i>K</i> =1.00)	To gain insight into looked-after young people's perceptions and experiences of factors related to SH ^a , and of interventions and services received.	<i>Sampling Method:</i> Purposive sampling 24 looked-after young people (20 female and 4 male, age=14-21) who had self-harmed in the previous 12 months. <i>Ethnicity:</i> Unknown	Individual semi-structured interviews lasting 18-82 minutes VAS ^b	IPA ^c	Five superordinate themes were identified: <i>Care Placement Changes:</i> Adolescents described care placement changes as highly important in either the cause or consequence of their SH ^a . <i>Feelings Of Anger:</i> Adolescents expressed experiencing feelings of anger and using SH ^a to get rid of these feelings, replace the feelings or protect others by turning the anger on themselves. <i>Not Wanting To Talk:</i> Some adolescents explained that they did not want to talk about their SH ^a , or felt unable to talk about it. <i>Developing Coping Techniques:</i> Many adolescents described independently developing their own coping techniques to deal with their SH ^a . <i>Experience of Clinical Services:</i> Adolescents described varying experiences of clinical services. Experiences of clinical services were therefore mapped onto three subthemes: Feeling Patronised (experiences of feeling patronised and not listened to by CAMHS ^d clinicians); Sense of Nothing Being Done (the

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					experience that nothing was being done by CAMHS to help them); and Feeling Comfortable (experiences of having a positive relationship with professionals, and feeling comfortable and willing to talk).
Crouch & Wright 2004 (UK) QR=19 (K=1.00)	To identify personal and interpersonal processes involved in SH ^a at a residential treatment setting for adolescents.	<i>Sampling Method:</i> Purposive sampling 6 adolescents (4 female and 2 male, age=12-16) in a UK inpatient unit, with a history of SH ^a . <i>Ethnicity:</i> 4 White British, 1 Black African and 1 Mixed Asian/ European	Individual semi-structured interviews, semi-projective techniques ^e and participant observation	IPA ^c	Nine superordinate themes were identified: <i>Precipitants of SH^a:</i> SH ^a was described as a response to conflicts with peers or family, or strong feelings of anger or distress. <i>Effects of SH^a on the Individual:</i> Adolescents described how SH ^a resulted in them feeling calm, and avoiding painful feelings. <i>Copying of SH^a:</i> Adolescents identified that copying and competition were common, and viewed negatively. <i>Secrecy:</i> Adolescents experienced their own SH ^a as a private act, and described how 'genuine' self-harmers were more secretive. <i>Group Definition and Difference Between Groups of Self-harmers:</i> Adolescents expressed that people who do not SH ^a cannot understand their experiences. They identified two categories of self-harmers, 'genuine' self-harmers and 'attention-seeking' self-harmers. <i>Behavioural Tariff:</i> Adolescents explained that SH ^a had to reach a certain severity to be seen as 'genuine'. <i>Hatred of the 'Attention-seeking' Self-harmers:</i> Adolescents expressed experiencing anger towards

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					<p>'attention-seeking' self-harmers, and a hatred of being perceived as an 'attention-seeking' self-harmer.</p> <p><i>Competition:</i></p> <p>Adolescents described experiencing competition to be recognised as the most 'genuine' self-harmer.</p> <p><i>Conflicted Views of SH^a:</i></p> <p>Adolescents expressed conflicting views of what they thought about SH^a, what constituted SH^a, and whether or not they did it. This resulted in subthemes regarding: Conflict About Groups (experiencing conflict about whether or not they were a self-harmer) and Conflict About Attention (experiencing conflict about whether or not SH^a relates to attention-seeking)</p>
Wadman et al. 2017b (UK) <i>QR</i> =19 (<i>K</i> =0.62)	To explore reasons why young adults repeat or maintain SH ^a and their perceptions of recovery.	<p><i>Sampling Method:</i></p> <p>Purposive sampling</p> <p>6 young adults (5 female and 1 male, age=19–21) with repeat SH^a for over 5 years.</p> <p><i>Ethnicity:</i> 5 White British and 1 Asian/ Asian British Pakistani</p>	<p>Individual semi-structured interviews lasting 28- 53 minutes</p> <p>VAS^b</p>	IPA ^c	<p>Six themes were identified:</p> <p><i>Keeping SH^a Private and Hidden:</i></p> <p>Young adults experienced SH^a as a private behaviour. They reported wanting to keep SH^a private, choosing body parts that could be covered and hiding it for many years.</p> <p><i>SH^a as Self-punishment:</i></p> <p>The young adults described SH^a as a form of self-punishment, due to feelings of guilt and shame.</p> <p><i>SH^a Provides Relief and Comfort:</i></p> <p>The young adults described feeling better due to gaining relief or comfort from SH^a, and this maintaining their SH^a.</p> <p><i>Habituation and Escalation of SH^a:</i></p> <p>Young adults experienced SH^a as becoming habitual. They presented SH^a as an uncontrollable, addictive behaviour that can escalate.</p> <p><i>Emotional Gains and Practical Costs of SH^a:</i></p>

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					<p>The young adults appeared to weigh up the emotional gains and practical costs of SH^a. They described the mess, and having to tend to wounds and wash stained clothes due to SH^a.</p> <p><i>Not Believing They Will Stop Completely.</i></p> <p>The participants experienced concern that they could not cope, and subsequently generally believed that they would not be able to completely stop self-harming.</p>
Lesniak 2010 (US) QR=18 (K=1.00)	To explore SH ^a by cutting as experienced by adolescent females.	<p><i>Sampling Method:</i></p> <p>Purposive and snowball sampling</p> <p>6 female adolescent (age=15–19) with current or previous SH^a by cutting.</p> <p><i>Ethnicity:</i></p> <p>Unknown</p>	Individual semi-structured interviews lasting 60-90 minutes	The Giorgi approach	<p>Nine themes emerged from the raw data:</p> <p><i>Living With Childhood Trauma:</i></p> <p>All of the adolescents described experiences of childhood trauma and abuse, which they had no control over and felt ill equipped to deal with.</p> <p><i>Feeling Abandoned:</i></p> <p>All of the adolescents described experiences of neglect, abandonment, disconnection, and a fear of being alone.</p> <p><i>Being an Outsider:</i></p> <p>The adolescents described wanting to be accepted, but feeling that they had no friends and no one to talk to who understood their SH^a.</p> <p><i>Loathing Self:</i></p> <p>The adolescents described experiences of self-loathing and low self-esteem associated with their SH^a.</p> <p><i>Silently Screaming:</i></p> <p>The adolescents described experiences of SH^a as a way to express feelings that they have difficulty expressing. They identified the subsequent wounds as a physical representation of their internal screaming due to the unexpressed emotions.</p>

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					<p><i>Releasing the Pressure:</i> The adolescents described turning to SH^a to seek relief from repressed emotions.</p> <p><i>Feeling Alive:</i> The adolescents described experiences of SH^a as a way to make their internal pain external and visible, and to feel alive.</p> <p><i>Being Ashamed:</i> The adolescents described experiences of shame and guilt as a result of their SH^a. They described trying to hide their SH^a, and being stigmatised due to it.</p> <p><i>Being Hopeful for Self and Others:</i> All of the adolescents described experiences of hopes and dreams for the future. They reported wanting to stop self-harming, finish high school, go to college and have a happy life and a good job, including careers that would enable them to help others.</p>
McAndrew & Warne 2014 (UK) <i>QR</i> =18 (<i>K</i> =0.62)	To explore adolescents engaging in SH ^a and suicidal behaviour's experiences of help and support.	<p><i>Sampling Method:</i> Purposive sampling</p> <p>7 female adolescents (age=13–17). <i>Ethnicity:</i> White British</p>	Individual semi-structured interviews lasting 45-60 minutes	IPA ^c	<p>Three themes were identified:</p> <p><i>Cutting out the Stress:</i> The adolescents described significant life events, and intrapersonal and interpersonal emotional turmoil as triggers for their SH^a. They reported experiences of positive consequences, such as relief, reinforcing the behaviour, and negative consequences of guilt and shame compounding their difficulties. They described experiencing stigma from others, which inhibited their help seeking.</p> <p><i>Stepping onto the Path of Help:</i></p>

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					<p>The adolescents described their experiences of difficulties accessing services, helpful services, and characteristics of helpers. A range of people were identified as being helpful in terms of being there for the adolescents, being available to talk, and providing support. Helpful characteristics included: trust, being listened to, confidentiality, not being judged, and being given an opportunity to talk to somebody independent.</p> <p><i>Cutting to the Chase:</i></p> <p>The final theme focused on what the adolescents thought could be done to help others who SH^a. They identified the importance of knowing who can help, education about SH^a and support options in school, and increased SH^a awareness.</p>
<p>Klineberg Kelly, Stansfeld & Bhui</p> <p>2013</p> <p>(UK)</p> <p>QR=17 (K=0.78)</p>	<p>To explore adolescents in the community's attitudes towards SH^a and experiences of SH^a disclosure and help seeking.</p>	<p><i>Sampling Method:</i> Purposive sampling</p> <p>30 adolescents (24 female and 6 male, age=15–16, No SH^a=10, 1 SH^a=9, repeated SH^a=11). <i>Ethnicity:</i> 4 White British, 12 Asian, 7 Black, 6 Mixed, and 1</p>	<p>Screening questionnaire and individual semi- structured interviews lasting 17–60 minutes</p>	<p>Framework approach (Content and Thematic analysis)</p>	<p>Five themes were identified: <i>Talking About SH^a:</i> The adolescents described a wide range of methods of SH^a (including self-cutting, self-battery, overdoses, self-burning and punching), and precipitants (including family problems, challenging relationships, trouble with schoolwork, and difficulty managing their feelings). They also described experiencing various feelings, including relief and regret.</p> <p><i>Suicide and SH^a:</i> Some of the adolescents implied that suicidal ideation was linked with their SH^a through indirect references to suicidal ideation; however, none directly reported clear suicide attempts.</p> <p><i>SH^a in Other People:</i></p>

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Unknown					<p>The adolescents described experiencing some difficulty comprehending SH^a in both themselves and in others. Some identified that knowing others who SH^a normalised their experiences.</p> <p><i>Disclosure and Secrecy About SH^a:</i></p> <p>Most adolescents described an initial reluctance to disclose SH^a, due to not viewing SH^a as an issue requiring discussion, preferring to keep their problems and SH^a to themselves or a fear of negative responses. They reported negative experiences of their SH^a being discovered, which reinforced their desire to maintain secrecy. However, some reported wanting their SH^a to be seen by others.</p> <p><i>Help-seeking:</i></p> <p>As most adolescents had never sought help, discussion of help-seeking related to their ideas about it, rather than their experiences. They described being unsure of where they could go for help, or what to expect. They hoped for confidentiality and respect, and for help to address the precipitating factors underlying their SH^a.</p> <p><i>Response to SH^a Without Help Being Sought:</i></p> <p>Some adolescents described experiences of help being offered without it being sought. They described subsequently feeling out of control over who knew about their SH^a.</p>
Mitten Preyde, Lewis, Vanderkooy & Heintzman	To explore perceptions of stigma and care of adolescents who have	<i>Sampling Method:</i> Purposive sampling	Individual semi- structured interviews lasting about	Content Analysis	<p>Three themes were identified:</p> <p><i>Stigma:</i></p> <p>The adolescents described experiences of stigmatising reactions from others, and stereotyping and labeling being helpful and unhelpful. They expressed experiences of</p>

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2016 (Canada) <i>QR</i> =17 (<i>K</i> =1.00)	received mental health care in a psychiatric hospital setting.	12 Canadian adolescents (10 female, 1 male and 1 other gender, age=14–19). <i>Ethnicity</i> : 10 Canadian Aboriginal, 1 Canadian and 1 Unknown	60 minutes.		<p>stigma between patients, and identified times when they stigmatised against others.</p> <p><i>Care Receipt</i>: The adolescents described positive experiences with health and mental healthcare providers, and the characteristics that made these good care providers.</p> <p><i>Stigma and Care Receipt</i>: Most adolescents described experiences of stigma during care receipt, with healthcare providers perceived as making assumptions about their appearance, diagnosis and behaviour, minimising their problems, and preventing them from accessing specialised services. They reported experiencing more accepting and positive care in the psychiatric unit compared to the emergency room.</p>
Moyer & Nelson 2007 (US) <i>QR</i> =17 (<i>K</i> =1.00)	To explore the meaning that SH ^a has to adolescents, to gain an understanding of what may lead to and maintain SH ^a .	<p><i>Sampling Method</i>: Purposive sampling</p> <p>6 adolescents (4 female and 2 male age=12-18). <i>Ethnicity</i>: 3 Caucasian, 2 Hispanic and 1 Caucasian/Hispanic</p>	Three separate individual semi-structured interviews	Constant comparison method	<p>Six themes were identified:</p> <p><i>The First Cut</i>: Several adolescents described experiences of learning SH^a from their friends. They described reluctance and hesitation prior to their first cut, due to being unsure whether or not it would help.</p> <p><i>A Tape Recorder in the Head</i>: The adolescents described constantly thinking about difficult situations in their lives prior to and during SH^a. They described purposefully thinking about the difficult situations whilst self-harming, and the thoughts playing repeatedly in their mind, like a broken tape recorder.</p> <p><i>A Way to Handle Life and Cope with Emotions</i>: The adolescents described using SH^a to escape thoughts, handle difficult situations and cope with emotions. The</p>

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					<p>reported experiences of feeling that SH^a was their only way to manage overwhelming emotions, and a lack of understanding from others.</p> <p><i>Feelings of Guilt, Shame and Regret:</i></p> <p>The adolescents described experiencing guilt, shame and regret after SH^a. They reported having to hide their wounds as a consequence SH^a.</p> <p><i>Not Wanting to Hurt Others:</i></p> <p>Most adolescents described experiences of emotional pain, and wanting to prevent this from being inflicted on others. They talked about self-harming to protect others and not hurt others physically or emotionally due to their anger.</p> <p><i>How They Wish to be Treated:</i></p> <p>The adolescents described experiences of different, helpful and unhelpful responses from others. They therefore expressed how they wanted others to respond. They recommended others listen with an open mind, and talk to them.</p>
<p>Rissanen, Kylma & Laukkanen</p> <p>2009</p> <p>(Finland)</p> <p>QR=17 (K=0.74)</p>	<p>To describe help and helpful factors from the viewpoint of Finnish adolescents who SH^a.</p>	<p><i>Sampling Method:</i></p> <p>Purposive sampling</p> <p>72 adolescents who SH^a (Gender unknown, age=12–21). <i>Ethnicity:</i> Unknown</p>	<p>62 written descriptions and 10 individual semi-structured interviews</p>	<p>Content Analysis</p>	<p>Three themes were identified:</p> <p><i>Any Person Who Knows About Their SH^a Can Be a Helper:</i></p> <p>The adolescents described experiences of others being sources of help. They identified peers, loved ones, and other adults as sources of help. Other adults included unknown adults, health and social care professionals, teachers and parents.</p> <p><i>Factors Contributing to Help:</i></p> <p>Several adolescents described factors that contributed to</p>

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					<p>help. These were presented as two subcategories: Factors that Enabled Help-seeking (awareness of needing help, knowledge of SH^a and help available, a caring environment and support from others), and Helpful Factors (awareness of ones' need for help, early intervention, learning to talk about SH^a and feelings, and authentic care).</p> <p><i>Help-hindering Factors:</i></p> <p>The adolescents also described help-hindering factors. These were presented as two subcategories: Factors Hindering Help-seeking (a lack of awareness of needing help, inability to seek help, experiences of shame, guilt and fear, and a lack of knowledge of SH^a and help available), and Unhelpful Factors (no intervention, and others unresponsiveness, misunderstanding and negative reactions).</p>
<p>Rissanen, Kylma & Laukkanen</p> <p>2008</p> <p>(Finland)</p> <p>QR=15 (K=0.80)</p>	<p>To describe SH^a from the perspectives of adolescents who SH^a.</p>	<p><i>Sampling Method:</i></p> <p>Purposive sampling</p> <p>70 Finnish adolescents who SH^a (69 female and 1 male, age=12- 21).</p> <p><i>Ethnicity:</i></p> <p>Unknown</p>	<p>Anonymous descriptions of SH^a sent to the researcher by emails or post</p>	<p>Inductive Content Analysis</p>	<p>Three themes were identified:</p> <p><i>Descriptions of the Factors Contributing to SH^a:</i></p> <p>Several adolescents described experiences of various external and internal factors that contributed to their SH^a. External factors included experiences of violence, life changes, substance misuse, an interest in Satanism, and family conflicts. Internal factors included experiences of conflicts, loneliness, changes, fear, isolation, poor self-esteem and negative emotions.</p> <p><i>Descriptions of the Act of SH^a:</i></p> <p>The adolescents described aspects of the act of SH^a. These were presented as two subthemes: Concrete Act of SH^a (including the methods, wound location and context), and</p>

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					<p>Intentions of the SH^a Act (their intentions behind their SH^a, including to: feel alive, externalise internal pain, gain control, punish themselves or others, experiment, pass the time, practice Satan worship, and to use SH^a as a possibility to kill themselves if needed).</p> <p><i>Descriptions of the Sequels of SH^a:</i></p> <p>The adolescents described experiencing personal and interpersonal consequences of SH^a. These included the personal consequences experienced by the adolescent, including positive, negative, and neutral feelings. They also described sequels for their relationships with significant others, who were either emotional or unresponsive, and experiences of healthcare staff intervening, or being unresponsive.</p>
<p>Bheamadu, Fritz, & Pillay</p> <p>2012</p> <p>(South Africa)</p> <p>QR=13 (K=1.00)</p>	<p>To explore SH^a experiences among adolescents and young adults within the South African context.</p>	<p><i>Sampling Method:</i></p> <p>Purposive sampling</p> <p>12 South African university students (11 female and 1 male; age=18-22) who SH^a in adolescence.</p> <p><i>Ethnicity:</i></p> <p>Unknown</p>	<p>Individual semi-structured interviews, personal writings and collages</p>	<p>Thematic Analysis</p>	<p>Three major thematic experiences of SH^a emerged:</p> <p><i>Biological Experiences:</i></p> <p>The participants described experiences of emotional and physical pain. They described physical pain as self-inflicted and controllable, compared to emotional pain, which was often described as global, abstract and uncontrollable. Several participants reported becoming psychologically addicted to SH^a, and experiencing cravings to SH^a.</p> <p><i>Psychological Experiences:</i></p> <p>The participants described various affective and cognitive experiences in relation to their SH^a. They described emotional experiences of anger and frustration prior to SH^a, and euphoria and revitalisation after SH^a. Several participants reported cognitive experiences of a desire to</p>

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					<p>SH^a to gain control.</p> <p><i>Social Experiences:</i></p> <p>The participants described how interpersonal experiences with family members and peers can serve as a buffer, or can exacerbate the experience of SH^a. This resulted in subthemes regarding: Social Experiences and Roles (the negative impact of a lack of boundaries and clear roles in the home), Peer Relations (positive experiences of connection with others who SH^a) and Isolation (negative experiences of isolation and feeling unable to express their thoughts and feelings).</p>
<p>Harvey & Brown</p> <p>2012</p> <p>(UK)</p> <p>QR=13</p> <p>(K=0.74)</p>	<p>To explore adolescents' accounts of SH^a to facilitate understanding in healthcare professionals and carers.</p>	<p><i>Sampling Method:</i></p> <p>Purposive sampling</p> <p>English speaking adolescents who submitted electronic messages to a teenage health website (Number of participants, age and gender unknown).</p> <p><i>Ethnicity:</i></p> <p>Unknown</p>	<p>A corpus of words from messages posted on an adolescent health website</p>	<p>Identifying statistical keywords to identify key themes (Baker, 2006)</p>	<p>Three themes emerged¹:</p> <p><i>Messages Concerning Friends:</i></p> <p>The adolescents described concerns about the self-harming behaviours of their friends, and wanting to help them stop. They described their friends' experiences of SH^a as a behaviour that is hard to stop, and is associated with depression and triggered by negative life events.</p> <p><i>Personal Experiences of SH^a:</i></p> <p>The adolescents described experiences underlying their SH^a. These included experiences of abuse, bullying, family turmoil and feeling upset and depressed. They constructed SH^a as a survival mechanism, to deal with their experiences and gain relief. Some adolescents also reported experiencing a dislike for their scars, and having to treat and hide them from others. Some described experiencing SH^a as an alternative to other risky behaviours.</p> <p><i>The Addictive and Habitual Quality of SH^a:</i></p>

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The adolescents described experiencing SH^a as compulsive, addictive and habitual. They described experiences of SH^a as part of a repetitive cycle that is liable to escalate. The adolescents described wanting and trying to stop, but feeling unable.

Note. *Sampling method included where provided by authors.

^aSH= Self-harm, referred to as Self-Injury, Non-Suicidal Self-Harm (NSSI) and Self-Mutilation within the papers reviewed.

^bVAS=Emotional State Visual Analogue Scale= emotional state ratings conducted before and after the interviews as a way of monitoring participant well-being and distress.

^cInterpretative Phenomenological Analysis

^dCAMHS= Child and Adolescent Mental Health Service.

^eSemi-projective techniques= Gain an understanding of the way a participant views the world, by asking them to tell a story about what is happening in an ambiguous picture.

It is anticipated that the participants will 'project' their own 'internal world', which is formed through experience, onto the picture.

^fThemes were described, but not clearly labelled by the authors. Theme names are therefore based on the authors' descriptions.

1.3.2. Analytic Review Strategy: Thematic Synthesis

The purpose of this review was to gain an understanding of adolescents' experiences of self-harm. There is growing recognition of the value of qualitative syntheses for evidence-based practice and policy decisions (Thomas & Harden, 2008). Qualitative syntheses enable the identification, amalgamation and translation of common and divergent themes from different studies, and increase the generalisability of their findings (Ring et al., 2011; Thomas & Harden, 2008). Qualitative syntheses go beyond the primary studies, as they offer novel interpretations derived from amalgamating all studies (Thorne et al., 2004). Thematic Synthesis (Thomas & Harden, 2008), the synthesis methodology utilised in this review, has been one of the leading methodologies in the field of healthcare (Ring et al., 2011). It has been utilised within several systematic reviews exploring people's perspectives and experiences within healthcare settings (e.g. Harden et al., 2009; Morton et al., 2010; Ridd et al., 2009; Lachal et al., 2015). Thematic Synthesis is derived from Thematic Analysis (Braun & Clarke, 2006), a method that is often used to analyse data in primary qualitative research to formalise the identification and development of themes (Thomas & Harden, 2008). Similar to other synthesis methodologies, such as meta-ethnography, reciprocal translation and constant comparison are utilised in Thematic Synthesis to describe, interpret and extend upon the original findings (Britten et al., 2002; Campbell et al., 2003).

Thomas and Harden's (2008) Thematic Synthesis procedure was utilised to conduct an inductive analysis of the data. The three overlapping stages in Thematic Synthesis are:

- Coding of findings

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- Developing descriptive themes
- Generating analytical themes

Consistent with this, the lead researcher electronically extracted, became familiar with, and line-by-line coded, all text regarding adolescent experiences of self-harm from the results and findings sections of the primary studies. Any direct quotes, in summaries or tables, were included to enable the synthesis to go beyond the findings. The lead researcher then inductively developed themes from the codes by looking for patterns or groupings in the codes, and comparing and translating the codes across the articles to identify similarities and differences. Hierarchical maps were then used to group the codes into themes. Finally, the lead researcher used the descriptive themes and abstraction to go beyond the original studies and produce new interpretations and summarising themes. Attempts were made to preserve the context of codes by creating structured summaries of each study, and regular research team meetings were held to discuss the descriptive and analytical themes, and subsequently increase the level of rigour (Evans, 2002).

1.3.3. Findings

The findings from the 12 papers included in this review will be reviewed in relation to main themes that emerged from the Thematic Synthesis (see Figure 1.2). Each theme will be explored in detail, and the research limitations and implications will be discussed. Quotation excerpts from the original studies are used to ensure that the adolescents' voices are included.

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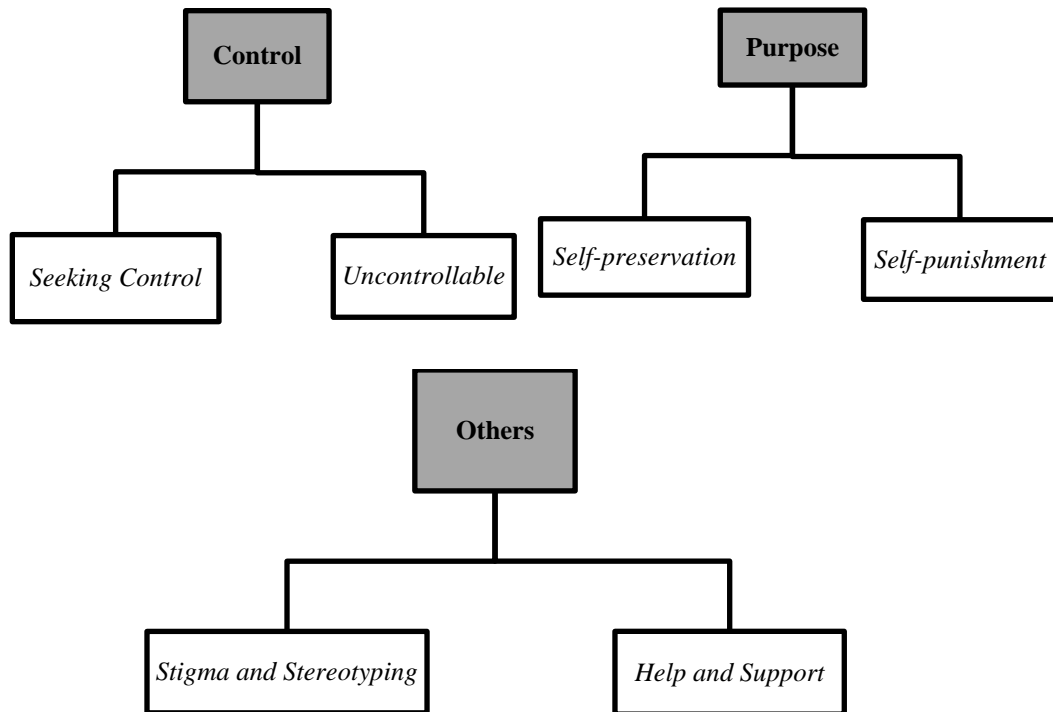


Figure 1.2. A thematic map displaying the themes identified.

The 3 main themes and subthemes were:

1. **Control** (*Seeking Control; Uncontrollable*)
2. **Purpose** (*Self-preservation; Self-punishment*)
3. **Others** (*Stigma and Stereotyping; Help and Support*)

The majority of studies added to all of the themes identified (Table 1.4 demonstrates articles contributions to the themes). The following discussion will therefore focus on particularly relevant studies within each theme.

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Table 1.4. *A table illustrating the contributions of each article to the main themes and subthemes.*

Main theme	Control		Purpose		Others	
Sub-theme	Seeking Control	Uncontrollable	Self-preservation	Self-punishment	Stigma and Stereotyping	Help and support
Wadman et al. 2017a	✓		✓		✓	✓
Crouch & Wright, 2004	✓	✓	✓		✓	
Wadman et al., 2017b	✓	✓	✓	✓	✓	
Lesniak, 2010	✓	✓	✓	✓	✓	
McAndrew & Warne, 2014	✓	✓	✓	✓	✓	✓
Klineberg et al., 2013	✓	✓	✓		✓	✓
Mitten et al., 2016	✓	✓		✓	✓	
Moyer & Nelson, 2007	✓		✓		✓	✓
Rissanen, Kylma & Laukkanen, 2009	✓		✓	✓	✓	✓
Rissanen, Kylma & Laukkanen, 2008	✓	✓	✓	✓	✓	✓
Bheamadu, Fritz, & Pillay, 2012	✓	✓	✓	✓	✓	✓
Harvey & Brown, 2012	✓	✓	✓	✓	✓	✓

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1.3.4. Themes

1.3.4.1. Control.

The first main theme 'Control' describes the narrative across all studies relating to adolescents' experience of lacking control. Adolescents described experiences of a lack of control in their lives, such as experiences of abuse and their housing placements unexpectedly being changed. They subsequently reported self-harming to gain a sense of control over their behaviour and emotions. Paradoxically, the adolescents also described their self-harm as becoming addictive and uncontrollable, with many adolescents explaining that they want to stop, but feel unable. The theme therefore includes two subthemes relating to adolescents' experience of 'Seeking Control', and experiencing self-harm as 'Uncontrollable'.

Seeking Control

Although intent differed between adolescents, all studies identified an underlying theme of self-harming to seek control in seemingly uncontrollable circumstances. This was described across genders, ethnicities and contexts. Wadman et al. (2017a) explored looked-after young people's experiences, and found that adolescents in care experience particularly low levels of control in their lives regarding their placements and contact with families, and this appeared to underlie much of their self-harm, "*I just didn't have no control into my life*" (p.6). For example, one young person explained that self-harm "*was my only way of controlling anything.*" (p.6). Wadman et al.'s (2017a) study was deemed to have the highest quality of all of the papers in the review, due to the detailed ethical considerations, confirmable analyses and use of measures to ensure validity and reflexivity.

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Moreover, adolescents in Moyer and Nelson's (2007) study described self-harming to control their emotions and their behaviour, *"Instead of, you know, going up to someone else, I can ... just do it to myself"* (p.46). Moyer and Nelson (2007) used a Constant Comparison method (Schwandt, 1997) to analyse interviews with six adolescents about the meaning that self-harm has to them. Adolescents described using self-harm to cope with thoughts, emotions and life situations, *"Like some people fight to let out anger. I don't do that. I hurt myself."* (p.46). They also reported subsequent feelings of guilt, shame and regret. The use of three separate interviews, member checking and researcher reflexivity reduced the likelihood of researcher bias, thus increasing the validity and subsequently the confirmability of the findings. However, the researchers provided a limited exploration of ethical considerations, study limitations and future research, and the Constant Comparison method may be more open to bias as researchers select which sections to code.

Uncontrollable

Despite the purpose of seeking control, the experience of self-harm as uncontrollable was a common narrative expressed by adolescents. This theme was particularly prevalent in the online messages analysed within Harvey and Brown's (2012) study, with many messages describing an inability to stop self-harming, *"i want to stop but i cant [sic]"* (p.326). The authors aimed to explore adolescents' accounts of self-harm, by identifying statistical keywords and themes within a corpus of 1.6 million words from messages posted on a UK-hosted adolescent health website. They found that participants described self-harm as habitual, addictive, and the only thing that they could do to manage their emotions. For example, participants wrote, *"I am worried that I am addicted to it cause whatever I do I can't stop"* (p.328) and *"the only way I feel I*

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can get rid of this depression is to harm myself" (p.329). The use of statistical keywords enabled the findings to be grounded in the data, and the use of an online website enabled the identification of data from a large sample, which was not influenced by researchers or unrealistic settings. Nonetheless, it is important to be mindful that Harvey and Brown's (2012) study had the second lowest quality of all the studies included in this review, because the anonymous nature of the website meant that the researchers were unable to obtain consent from participants, access demographic information or ask for further detail and clarification.

Furthermore, Klineberg et al. (2013) identified that many of the adolescents in their study described the experience of being 'found out' as uncontrollable, as they were frequently provided with help that they had not sought or wanted. 30 ethnically diverse adolescents, including nine who had self-harmed on one occasion and 11 who self-harmed repeatedly, were interviewed about their attitudes towards and experiences of self-harm disclosure. Using a Framework approach, a combination of Content and Thematic Analysis, they found that adolescents described a range of disclosure experiences, including feeling angry due to peers disclosing their self-harm. For example, one participant reported, *"I was angry, because... I didn't know she told, so I was like, "Why didn't you tell me?"*" (p.7). The large, ethnically diverse sample, including 6 males, was a strength of the study. Additionally, the use of multiple coders and a review of coding consistency increased the auditability of the analysis, and subsequently the confirmability of the findings. The detailed discussion of child safety considerations, limitations, and future implications further increased the quality of the study. However, the use of Content Analysis, and the focus on attitudes led to more descriptive and less detailed experiences, compared to other studies that utilised IPA

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(Wadman et al., 2017a). Moreover, the researchers acknowledged limitations of using a single retrospective interview to discuss such a sensitive topic, as they found that many of the adolescents had difficulty constructing a coherent story from their recollections, so may not have been able to fully explain their experiences.

1.3.4.2. Purpose.

The second main theme 'Purpose' depicts the main functions and outcomes of self-harm that the adolescents described experiencing. It includes another paradox evident in adolescents' reports. The adolescents described how self-harm is something that they can do to make themselves feel better or ask for help, and is therefore distinct from suicidal behaviour. Paradoxically, they also identified how self-harm can be a way to punish themselves due to feeling that they deserve the pain, which could progress onto suicidal behaviour. An adolescent in Wadman et al.'s (2017b) study clearly explained this, "*...it feels like two reasons really. One, I deserve it. Two, it helps.*" (p.1636). Therefore, the theme comprises of two subthemes describing adolescents' experience of self-harm as a form of 'Self-preservation', and 'Self-punishment'.

Self-Preservation

The studies identified multiple purposes of adolescent self-harm, including, to communicate, express and externalise emotional pain, and feel better (Moyer & Nelson, 2007). South African adolescents interviewed in Bheamadu et al.'s (2012) study experienced self-harm as the only thing that could make them feel better, stating that it led to "*this euphoric feeling-a kind of high afterwards*" (p.264). The researchers conducted interviews with 12 South African university students who self-harmed in adolescence. Participants were also asked to complete collages, journal entries and personal written work of their thoughts, feelings and behaviours during self-harm.

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Analysing the data using Thematic Analysis, the researchers found that the students used self-harm to alleviate intense intrapersonal and interpersonal distress, and that it was associated with a range of biological, cognitive, psychological and social experiences. This study was rated as the poorest quality in the review, due to the retrospective design, the lack of detail regarding how the data analysis was audited, and a limited discussion of previous research, limitations and future implications. Nonetheless, similar experiences were also evident in many of the accounts of the adolescents in Rissanen et al.'s (2008) larger study, which analysed written descriptions of self-harm from 70 non-clinical Finnish adolescents and identified a range of intentions underlying self-harm. This included externalising pain or anxiety, feeling better and more alive, and communicating how they feel or asking for help, *"I wish someone would see my cuts and scars and help me."* (p.156). While the method of collating written descriptions of self-harm reduced selection bias, facilitated a large, broad sample, and enabled participants to guide the content, it resulted in highly descriptive accounts, with a lack of abstraction, or further exploration of responses. Additionally, there was limited exploration of ethical considerations and reflexivity, reducing the confirmability of the findings.

Consistent with this, adolescents in a range of studies identified a clear distinction between suicide attempts and self-harm, with regards to their methods and motivation, *"what none of my friends understand is I'm not doing it for suicide reasons. I don't want to kill myself"* (Harvey & Brown, 2012, p328). American adolescents interviewed in Lesniak's (2010) study described how their self-harm was distinct from suicide. Using the Giorgi approach (Giorgi, 1997) the authors identified themes regarding adolescents' experiences of using self-harm to feel alive and prevent suicide.

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The authors wrote detailed descriptions about participants, explaining that “*Cutting made Emma not want to die; instead, she cut to feel alive.*” (p.143). This study was deemed to be of high quality, due to the high auditability of the study. However, the findings were limited by the lack of direct quotes used within the findings. Additionally, while the sample size was adequate, it was likely biased by the large number of adolescents who declined to take part due to the requirement of parental consent.

Self-Punishment

As well as the intent of feeling better, many adolescents described self-harming with the intent of punishing themselves, “*there’s like an element of like self-punishment type thing*” (Wadman et al., 2017b, p.1635). For example, Wadman et al. (2017b) interviewed 6 young adults in the UK about their experiences of self-harm and found that self-punishment was one of the most clearly articulated reasons given for self-harming by the young adults recalling their self-harm in adolescence. The participants described self-harming due to guilt and frustration, and believing they deserved it, “*I felt really guilty for annoying my family for upsetting ... and then I just wanted to hurt myself because I felt like I deserved it at the time*” (p.1635). The quality of the study was rated highly, as the use of an advisory group for question development, as well as IPA and an audit trail for the analysis facilitated high transparency and validity. However, the findings were limited by the retrospective accounts. Nonetheless, the adolescents interviewed in Lesniak (2010), McAndrew and Warne (2014) and Rissanen et al.’s (2008) studies described similar experiences of using self-harm to punish themselves due to self-hatred, “*I felt worthless and I thought I deserved this pain*” (Rissanen et al., 2008, p.155).

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Moreover, linked to the self-punishment, and in contrast to the differences between self-harm and suicidal behaviours described by some adolescents (Crouch & Wright, 2004), adolescents in Rissanen et al.'s (2008) study described how self-harm could progress onto suicidal thoughts and behaviours, *"I continued this foolish thing for a couple of years, but it ended when I tried to commit suicide"* (p.157), and *"If someday I feel terribly bad, self-mutilating is the best way to kill myself."* (p.156).

1.3.4.3. Others.

The final 'Others' main theme derived from adolescents' accounts of their divergent experiences with other people. These included peers, family members, health and social care professionals, and others adults, such as school staff and youth leaders. They reported positive experiences of disclosure leading to support and normalisation from others. The adolescents also described negative experiences of disclosure, as well as experiences of stigmatisation from peers. These negative experiences result in a subsequent fear of negative responses and an avoidance of disclosure. Therefore, the theme included paradoxical subthemes of 'Stigma and Stereotyping', and 'Help and Support'.

Stigma and Stereotyping

The majority of adolescents in the studies in this synthesis reported experiences of stigma or stereotyping in relation to their self-harm, and this was particularly evident in inpatient settings (Crouch & Wright, 2004; Mitten et al., 2016). Crouch and Wright (2004) explored the personal and interpersonal processes related to self-harm for six adolescents in a UK inpatient unit who had a history of self-harm. They conducted interviews, with semi-projective techniques and participant observation, and utilised

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IPA to analyse the interviews. The adolescents' narratives demonstrated frequent stereotyping and stigmatising between patients. Adolescents described the stereotypes of "*genuine self-harmers*", who self-harm severely and in private, and "*attention seekers*", for whom self-harm is generally more superficial and less hidden, "*some people do that for attention, but then a lot of self-harmers don't do it for attention as well, there's two different categories.*" (p.193). Adolescents perceived secrecy as a sign of being a "*genuine self-harmer*", "*the people doing it for release ... do it quietly and discretely.*" (p.194). They described anger and increased competition, secrecy and severity due to disliking being perceived as an "*attention seeker*", "*a thing that really works me up is when people say that I'm attention seeking*" (p.195). The use of triangulation, IPA, and a second investigator and independent researcher to check the interpretative process were strengths of this study. Additionally, the hypothetical nature of the semi-projective techniques likely made the interviews less threatening for the adolescents, subsequently facilitating their ability to express their experiences. Nonetheless, the validity of the findings is limited by the lack of respondent validation, and limited use of direct quotes. Moreover, Mitten et al. (2016) acknowledged that the author's exploration of themes around care receipt was likely limited due to it being an unexpected result of their exploratory research.

To address this, Mitten et al. (2016) explored 12 adolescents' perceptions of stigma and care in an inpatient unit in Canada, and also identified stigma as a common topic in the adolescent's narratives. In individual interviews, adolescents reported varied experiences of care receipt and stigma from both clinicians and other patients. They described experiencing common stigmatising reactions from peers, "*A lot of people would just say like ew [sic], that's ugly*" (p.9), and clinicians, "*they kind of just wanted*

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you out of there, they didn't believe me, which hurt" (p.13). The researchers provided appropriate detail regarding the research rationale, context and recruitment, as well as ethical considerations. Additionally, member checking increased the confirmability of the findings. However, the use of Content Analysis reduced the depth of the findings (Vaismoradi, Turunen & Bondas, 2013), and the poor response rate (27%) limits the transferability of the findings. Moreover, the retrospective accounts may have been impacted by adolescents' mental health at the time, and their perceptions of the inpatient unit.

Themes around stigma and stereotyping have also been replicated in community settings, and the notion that self-harm had to subsequently be hidden and secretive was common across studies (Klineberg et al., 2013; Wadman et al., 2017b). For example, an adolescent in McAndrew and Warne's (2014) study explained, "*'Cos people say, we do it for attention or we want to kill ourselves or whatever*" (p.573). McAndrew and Warne (2014) interviewed seven female adolescents engaging in self-harm and suicidal behaviours and found that stigma and stereotyping from others was a prominent part of adolescents' experiences. Concerns about what others would think led to further perceptions of stigma, a fear of being judged and subsequently difficulties disclosing, "*I was thinking, what will he (general practitioner) think, if I was going to be judged, which put me off going*" (p.573). This study was rated highly in the quality assessment, due to the detailed discussion of the rationale, philosophy, use of IPA and ethical considerations, as well as the use of an independent researcher to audit themes, assuring authenticity and credibility. Similarly, Klineberg et al. (2013) and Wadman et al. (2017b) found that most adolescents reported that negative experiences of being discovered reinforced their desire to maintain secrecy. Additionally, adolescents in

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many of the studies described choosing to harm themselves in places that cannot be seen by others, and wearing clothes to cover their scars (Lesniak, 2010; Rissanen et al., 2008). For example, an adolescent in Wadman et al.'s (2017b) study explained, "*I made sure to do it [self-harm] sort of quite high up [on my thigh]*" (p.1635). Moreover, the adolescents in care in Wadman et al.'s (2017a) study described how they kept their self-harm a secret because they did not trust other people, and did not want other people to "*get involved*" (p.7).

Help and Support

Despite reluctance to disclose self-harm to others, most of the studies identified themes around gaining help and support from others (Wadman et al., 2017a). Klineberg et al. (2013) found that adolescents who had ceased self-harming viewed disclosure more positively with hindsight, "*Actually it did make me feel better... I didn't want them to know, but it made me feel better in a way.*" (p.6).

Exploring experiences of help specifically, Rissanen et al. (2009) recruited 72 Finnish adolescents who self-harm, and asked 62 to write descriptions and interviewed 10 about their experiences of help. The adolescents described helpful experiences with their friends, partners and fellow self-harming adolescents, "*A fellow self-mutilating adolescent who knows what it is all about can understand and support me*" (p.9). Helpful experiences with other adults, such as parents, health and social care professionals, teachers and school counsellors were also described. Rissanen et al. (2009) also identified factors that helped adolescents and contributed to help seeking, such as understanding, early intervention, and authentic caring. The use of interviews as well as written descriptions enabled a large sample, whilst facilitating further

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exploration within the interviews. The researchers also provided a detailed discussion of limitations and conclusions, and included multiple quotes in results section, improving the validity of the results. Nonetheless, the findings were limited by the lack of reflexivity and a single coder, and the use of Content Analysis may have reduced the depth of the findings (Vaismoradi et al., 2013). Additionally, the written descriptions were anonymous, therefore age, gender and ethnicity were unknown, and answers could not be explored further.

These findings were replicated in McAndrew and Warne's (2014) study, as adolescents described the benefits of talking to fellow self-harming peers, and a range of adults who helped them, such as a church pastor, deputy year head and youth leader. Adolescents also described similar helpful factors, including confidentiality, trust, being listened to and others being caring, and supportive, and listening non-judgementally, *"The counsellors are very calm, and I think that calms you. They are very understanding... They are caring as well"* (p.574).

1.4. Discussion

Three main themes were identified from the 12 articles reviewed. Whilst many themes were largely consistent with previous research, the paradoxes between themes demonstrated the paradoxical nature of experiences, which was a novel finding that builds upon the findings of the individual studies and previous reviews.

1.4.1. The Self-Harm Paradox

The findings identified that the paradoxical relationship can be understood in relation to control, purposes of self-preservation or self-punishment, and stigmatising

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and stereotyping responses, or helpful and supportive responses from others, including peers, parents, professionals and other adults. With regards to the paradox of control, self-harm has previously been widely acknowledged as a means of controlling one's life and feelings (Boynton & Auerbach, 2004; Plante, 2007). Consistent with the findings of this synthesis, previous research has shown that adolescents who are unable to control difficult and traumatic events in their lives, such as abuse, loss, family conflict and bullying, often self-harm to gain control (Cleaver, 2007). Paradoxically, the current synthesis identified a seemingly counterintuitive experience of self-harm being experienced as uncontrollable, and at times addictive (Wadman et al., 2017b). The reported addictive nature of self-harm is controversial and has been largely contested (Sutton, 2005). However, adolescents who self-harm have frequently described self-harm as a behaviour that is very difficult to stop (Harvey & Brown, 2012). Adolescents therefore appear to be in a double bind, lacking control over the only behaviour that provides them with some degree of control over their lives (Harvey & Brown, 2012). This double bind was also identified in Lachal et al.'s (2015) review of suicidal behaviours, as young people described simultaneous experiences of a loss of self-control over suicidal behaviours and suicidal behaviours as an attempt to regain control.

The paradox of self-harm as a form of self-preservation or self-punishment supports previous research that has demonstrated that it is difficult to establish a unified function of self-harm (House, 2014), and may in part explain why self-harm is difficult for adolescents to stop or replace (Harvey & Brown, 2012). On the one hand, adolescents described self-harming to feel better, and more alive. Moreover, consistent with Lindgren et al.'s (2017) review of adults' self-harm experiences, some adolescents used self-harm to seek help and elicit care. McAndrew and Warne (2014) reflected on

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how these positive consequences likely reinforce the behaviour and increase the likelihood of repetition. Furthermore, consistent with research demonstrating that self-harm and suicidal behaviours have divergent functions (Klonsky & Muehlenkamp, 2007; Weiner, 2016), many adolescents described self-harm and suicide attempts as completely unrelated behaviours. On the other hand, some adolescents described how self-harm can also be a form of self-punishment, as they self-harmed because they felt that they deserved to be punished and feel pain (Lesniak, 2010). It could be argued that the self-punishment aspect of self-harm described by the adolescents actually served the purpose of self-preservation, as it may have been a way to alleviate their distress (Klonsky, 2007). Nonetheless, there appeared to be divergence and a paradoxical relationship, as many adolescents described self-punishment in the context of their experience of believing that they deserved to be punished and feel pain. Adolescents also explained how self-harm can progress onto suicide (Rissanen et al., 2008), which is consistent with the finding that adolescents who self-harm are at a greater risk of suicide (McManus et al., 2016). This supports the finding that when self-harm becomes ineffective, adolescents feel hopeless and out of control, resulting in suicidal behaviours (Gong et al., 2019; Harvey & Brown, 2012).

In relation to the paradoxical influence of others, the experience of stigma was common across studies, and appeared to reinforce self-harm and secrecy (McAndrew & Warne, 2014; Crouch & Wright, 2004). Self-harm has been described as a highly misunderstood and stigmatised behaviour (Harris, 2000). As a consequence, many adolescents find ways to hide their self-harm and keep it a secret from others, by wearing clothing to hide wounds (Shannon, 2005). Furthermore, consistent with Lindgren et al. (2017), it was identified that many adolescents feared disclosing self-

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harm due to previous negative experiences of being misunderstood and judged.

Similarly, Lachal et al. (2015) found that adolescents with suicidal behaviours also described experience of incomprehension and of feeling unheard. Despite a subsequent avoidance of disclosing self-harm, many adolescents described the benefit of the help they received, and how this help and support had led to a reduction in their self-harm (McAndrew & Warne, 2014). Additionally, similar to the adults in Lindgren et al.'s (2017) review, adolescents experienced a range of factors as helpful, including staff who were respectful, caring, genuine, proactive and supportive, and identified that therapy was necessary for their recovery. This indicates that the stigma and stereotyping associated with self-harm may lead to young people putting off accessing early help from effective services that would likely reduce their self-harm behaviours.

1.4.2. Clinical and Policy Implications

These findings have many implications for both clinical practice and policy changes. With regards to clinical practice, it would be useful for clinicians to be aware of the paradoxes identified, to enable them to have more understanding of the double bind the adolescents may be experiencing, and why it may be particularly challenging for them to stop self-harming without an alternative strategy, or the underlying mental health issues being addressed. In relation to the paradox of control, it is crucial for clinicians to be aware that adolescents who self-harm may not feel in control of the behaviour, and may feel unable to give up their only way of gaining control. It would therefore be beneficial for training to encourage professionals to support adolescents to find alternative strategies to replace self-harm, and empower them to gain control over the self-harm and manage their emotions. Similar to previously described educational and reflective interventions that have improved professionals' understanding of self-

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harm (Hawton, Saunders & O'Connor, 2012; Holdsworth, Belshaw & Murray, 2001; Patterson et al., 2007), this training could be run by Clinical Psychologists, and include reflective and educational sessions regarding the various functions of self-harm. Additionally, Clinical Psychologists could provide formulation sessions, to support professionals in formulating and understanding adolescents' individual presentations of self-harm, and subsequently developing formulation-driven person-centred interventions for the adolescents.

Furthermore, with regards to the paradoxical purposes of self-harm, it would be useful for clinicians to understand that self-harm can have multiple, seemingly counterintuitive functions. It would be helpful for clinicians to ask the adolescents they work with about their understanding of the functions of their own self-harm, and be aware that these may change overtime. Additionally, the finding that many adolescents self-harm to manage or avoid difficult emotions or experiences, indicates that it would be beneficial for clinicians to address these underlying difficulties.

Moreover, it is recommended that professionals are informed that they can be experienced as both helpful and stigmatising by adolescents, due to their previous experiences of disclosure and services. Based on the 'helpful factors' identified in the synthesis, professionals should aim to provide early intervention for adolescents who self-harm, and be understanding, supportive, caring and non-judgmental. It may also be empowering for clinicians to be made aware that many of the adolescents experienced professional interventions as helpful.

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The main policy implication is the need for an increase in general awareness and education regarding self-harm in adolescence, to reduce the societal stigma and stereotyping that is evident. This increased awareness and understanding may also increase the availability of supportive adults for adolescents to access, as the adolescents described the benefit of accessing various supportive adults, including a church pastor and youth leader. Additionally, funding for the provision of peer support and therapeutic groups for adolescents who self-harm is recommended, based on the adolescents' descriptions of the normalising benefits of talking to fellow self-harming peers.

1.4.3. Limitations and Future Research Directions

There are four important limitations that need to be considered and addressed in future research. Firstly, the study is limited by the failure to explore the influence of gender on adolescents' experience of self-harm. Quantitative studies have identified important gender differences in adolescent self-harm (Evans, Hawton & Rodham, 2005; Laye-Gindhu & Schonert-Reichl, 2005). A consideration of the role of gender in the synthesis was not possible due to the largely female samples, which may be a result of the higher rates of self-harm in female adolescents (Madge et al., 2008). Despite this, research has demonstrated that the prevalence of female adolescents with current or historic self-harm in the UK is 23.1%, compared to 7.1% in males (Morey et al., 2016), so the small proportion of males included within most studies was not representative. Future qualitative studies and syntheses investigating adolescents' experiences of self-harm should therefore consider the role of gender.

Secondly, the exclusion of studies exploring solely suicidal behaviours is

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another limitation of the synthesis, as differentiating the self-harm and suicidal behaviours in the context of research and practice has proven to be challenging (Zayas et al., 2010). The focus on self-harm behaviours specifically was deemed appropriate for the synthesis given the divergent forms and functions of self-harm and suicidal behaviours (Gulbas et al., 2015; Klonsky & Muehlenkamp, 2007). Nonetheless, the inclusion of studies exploring suicidal behaviours in future research may add to the understanding of self-harm and suicidal behaviours in adolescents.

Furthermore, the recent shift towards qualitative syntheses has received much criticism (Ring et al., 2011). For example, researchers have argued that the methods are less developed (Thomas & Harden, 2008), and that syntheses de-contextualise findings and attempt to synthesise studies that are not commensurable (Campbell et al., 2003; Sandelowski & Barroso, 2007). Nonetheless, it has been argued that qualitative syntheses should be included in the research toolkit, as they provide a deeper level of interpretation that enables novel insights, increased understanding, and important implications (Lachal et al., 2017).

Finally, while exploring adolescents' self-reported experiences of self-harm offered valuable insights, the approach was limited as the adolescents may have been unable to verbalise their experiences (Brown & Wright, 2003), or they may have minimised their experiences due to the shame and stigma associated with self-harm (Klonsky, 2007). Furthermore, researchers have argued that requiring vulnerable individuals to talk about sensitive issues can exacerbate distress (Lakeman & Fitzgerald, 2009). However, Biddle et al.'s (2013) recent review demonstrated that participants are more likely to experience benefit than harm, and adolescents' perspectives are often

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misunderstood and invalidated when assessed through respondents (Adams, Rodham, & Gavin, 2005; Harvey & Brown, 2012). Additionally, consistent with previous recommendations (Lakeman & Fitzgerald, 2009), two of the studies utilised participant well-being measures, and demonstrated that participants scored their emotions positively, and did not experience a significant change in their emotional state (Wadman et al., 2017a, 2017b). Nonetheless, future syntheses should consider the experiences of family members, as well as the adolescents, to gain a broader and more accurate understanding of experiences.

1.5. Conclusion

The review employed Thematic Synthesis, a rigorous and frequently utilised method, to integrate qualitative research exploring adolescents' experiences of self-harm. This addressed an important gap in the literature, as previous reviews have failed to draw together the available qualitative research exploring adolescents' experiences of self-harm (Lachal et al., 2015; Lindgren et al., 2017). The synthesis is largely consistent with previous findings, and meets the criteria of the principal protocol used in qualitative research syntheses (Tong et al., 2012, see Appendix E), increasing the strength of the findings (Zimmer, 2006). The synthesis has added to previous literature by gaining a novel understanding of adolescents' paradoxical experiences and identifying clinical implications and areas for future research. The paradoxes demonstrate the double bind that adolescents who self-harm are in, and the reinforcing nature of their experiences. The adolescents' experiences and descriptions indicate that self-harm can occur for several reasons and fulfil multiple functions (McAndrew & Warne, 2014). The adolescents' descriptions indicate that self-harm is often an attempt to control their internal world, either through self-preservation or self-punishment,

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which can become uncontrollable and difficult to stop. The synthesis has provided an understanding of how adolescents conceptualise experiences of self-harm as distinct from, but related to, suicidal behaviours. Moreover, the paradoxical experiences of other people, including peers, parents and professionals, as both helpful and stigmatising demonstrated that the stigma associated with self-harm can be a barrier to accessing and benefitting from services.

Nonetheless, the findings are limited by the reliance on self-reports from a predominantly female sample, with the exclusion of suicidal behaviours. Further research is therefore required to explore the role of gender, and males' experiences of self-harm. Similarly to the higher quality studies included in this synthesis, these studies should utilise in-depth data collection and analyses methods, such as IPA, and include considerations of reflexivity through reflective logs, and multiple coders. Future syntheses should also consider including the experiences of individuals in the adolescents' system, such as family members and professionals who are involved with adolescents who self-harm, and the experiences of adolescents who display suicidal behaviours.

Finally, this synthesis should be utilised to enhance clinical practice, by increasing professionals' understanding of the multiple purposes of self-harm, and how they can best support and work with these vulnerable young people.

1.6. References

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Chapter 2: Empirical Paper

A Qualitative Exploration of CAMHS Nurses' Experiences of Working with Adolescents who Self-harm.

*Prepared for submission to the Journal of Clinical Nursing (please refer to Appendix F
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2.0. Abstract

Aims and Objectives: The aim of this research was to gain an understanding of Child and Adolescent Mental Health Service nurses' experiences of working with adolescents who self-harm in the community. **Background:** Self-harm rates are increasing, with rates twice as high in adolescents relative to adults. Nurses are the frontline professionals who often work with adolescents who self-harm in the community. Qualitative research has begun to explore nurses' experiences of working with adults who self-harm. An under investigated area of study is nurses' experiences of working with adolescents who self-harm in the community. **Method and Design:** Within an interpretative, qualitative approach, 10 qualified nurses (2 male; aged 25 to 55 years; *Age*= 33 years; mean length of experience=6.5 years) working in two West Midlands' NHS Trusts were interviewed about their experiences of working with adolescents who self-harm. One-to-one semi-structured interviews were conducted and analysed using Interpretative Phenomenological Analysis. **Findings:** Two superordinate themes emerged, each consisting of two subordinate themes: '*Personal and Professional Conflicts*', describing the interpersonal and intrapersonal conflicts the nurses experienced working with adolescents who self-harm and the systems around them, and '*Personal and Professional Development*', outlining the development the nurses have made and the ways they have learnt to manage the conflicts they experience. **Conclusions:** The nurses' experiences of personal and professional conflicts and development are considered in the context of previous research. **Relevance to clinical practice:** Clinical implications regarding training and support for nurses, and directions for future research are discussed.

Word count: 236

Key words: *nursing, adolescent, self-harm, qualitative research, IPA, mental health.*

2.1. Introduction

2.1.1. Adolescent Self-harm

The purpose of this study is to explore Child and Adolescent Mental Health Service (CAMHS) nurses' experiences of working with adolescents who self-harm. A wide variety of behaviours have been identified as forms of self-harm, including burning, cutting, overdosing and ingesting toxic substances (Mitten et al., 2016; Mental Health Foundation [MHF], 2006). Adding to this ambiguity, a wide range of terms for self-harm have been utilised by scholars, such as parasuicide, self-mutilation or cutting, deliberate self-harm, self-poisoning and non-suicidal self-injury (Fox, 2011). The definition of self-harm therefore currently lacks consensus (Ougrin, Ng, & Zundel, 2009). Given ambiguity regarding intent, and that clinicians report difficulty distinguishing between suicide and self-harm (Lundegaard, Mattson & Binder, 2012), this study will utilise the National Institute for Health and Care Excellence's (NICE; 2011) broad definition of self-harm as a behaviour that involves "any act of self-poisoning or self-injury carried out by an individual irrespective of (his or her) motivation" (p. 4).

Self-harm rates in the UK are increasing (McManus et al., 2016), with rates twice as high in adolescents relative to adults (Ferrara, Terrinoni, & Williams, 2012). Although prevalence rates are difficult to estimate due to adolescents frequently not disclosing self-harm, or presenting to services (Doyle, Treacy & Sheiridan, 2015), research has found that 15%-20% of adolescents engage in self-harm (Heath, Schaub, Holly, & Nixon, 2009). Furthermore, adolescents are the most prolific self-harmers (Dickinson, Wright & Harrison, 2009) and are at a high-risk of repetition and suicide (Cooper et al., 2005). Adolescent self-harm has therefore been internationally

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recognised as a major healthcare problem (Greydanus & Shek, 2009).

2.1.2. Self-harm and Healthcare Professionals

Adolescents' contact with professionals can have a significant impact on treatment outcomes, self-harm repetition and future help seeking (Anderson, Standen, & Noon, 2003; Fox, 2011). Given the ambiguity around the definition of self-harm, it is still largely misunderstood by professionals (MHF, 2006). Adolescents have frequently reported that being misunderstood by professionals results in experiences of feeling ignored, judged and invalidated (Adams, Rodham, & Gavin, 2005; McHale & Felton, 2010).

Ample evidence has also shown that professionals working with adolescents who self-harm experience negative attitudes, in part due to a lack of training (Cleaver, 2014; Carter, Latif, Callaghan & Manning, 2018; Karman, Kool, Poslawsky & van Meijel, 2015). Consistent with this, adolescents report experiencing negative attitudes and hostile responses from professionals (Cook, Clancy & Sanderson, 2004; MIND, 2014; Royal College of Psychiatrists [RCP], 2010), which can greatly impact treatment outcomes (Ashcroft, Caulfield & Proctor, 2013; Wadey, Trenchard & Knowles, 2013) and lead to premature self-discharge and reduced future help seeking (RCP, 2010; Shepperd & McAllister, 2003).

Research exploring professionals' attitudes has also provided insight into the emotional impact of working with adolescents who self-harm, as negative attitudes have been found to be accompanied by feelings of anxiety and negativity (Cleaver, 2014; Wheatley & Austin-Payne, 2009).

2.1.3. Investigating Experiences

It is important to understand professionals' experiences of working with adolescents who self-harm, as nurses describe self-harm as difficult to manage (Huband & Tantam, 2000) and working with this population has been recognised as emotionally demanding by NICE (2004). This emotional impact is needs to be explored, as strong evoked emotions can negatively impact therapeutic relationships (Wilstrand, Lindgren, Gilje & Olofsson, 2007).

Additionally, investigation of professionals' experiences of working with adolescents is of high importance (Cleaver, 2014). This is because the emotional impact is likely to negatively impact the emotional well-being of professionals, as work-related stress has been consistently linked with poorer well-being, burnout and subsequent mental and physical health difficulties (MHF, 2010; Mindfulness All-Party Parliamentary Group [MAPPG], 2015). Furthermore, the current high rates of stress and burnout (Dall'ora, Griffiths, Ball, Simon & Aiken, 2015) have been shown to cost the National Health Service (NHS) between £300m to £400m a year (NHS Employers Organisation, 2014), and are likely linked to the current high rates of staff turnover in the NHS (Davies, 2014).

Moreover, the need for research exploring professionals' experiences has previously been recognised (Timson, Priest, Clark-Carter, 2012). Therefore, while previous research exploring attitudes has been informative, a more in-depth understanding of professionals' own experiences of working with adolescents that self-

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harm is required, to inform effective staff support systems and subsequently improve patient care (NICE, 2004).

2.1.4. Previous Qualitative Literature

A search of the current literature identified four principal studies utilising qualitative approaches to investigate nurses' experiences of working with individuals who self-harm. In one key study, Lundegaard, Mattson and Binder (2012) interviewed healthcare workers (5 nurses, 2 social educators and 1 psychologist) in a secure inpatient setting in Norway about their experiences of working with clients who self-harm. Using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009), they identified themes regarding experiencing frustration when using coercive strategies, changing from coercion to alliance, useful ways of working with self-harm and the challenge of distinguishing suicide attempts and self-harm. However, Lundegaard et al.'s (2012) findings were largely focused on the healthcare workers' experience of service change whilst working with clients who self-harm, and were not specifically nurses' experiences.

Focusing on nurses, Tofthagen, Talseth and Fagerstroem (2014) interviewed fifteen mental health nurses in Norway about their experiences of caring for adult inpatients who self-harm during an acute phase. Using Content Analysis, they found that nurses described wanting to understand the self-harm, being hopeful, and being emotionally affected by self-harm clients; experiencing the clients' difficult emotions. The nurses also described recognising triggers, monitoring risk, and managing self-harm, wound care and medication. However, Tofthagen et al.'s (2014) findings mainly focused on the care the nurses provided, rather than their experiences of working with

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the adults.

Similarly, Wilstrand et al. (2007) asked psychiatric nurses in Sweden to narrate satisfying and unsatisfying experiences providing care for inpatient clients who had self-harmed. They utilised Content Analysis to identify two main themes of 'being burdened with feelings', which encompassed feelings of anxiety, frustration and abandonment, and 'balancing professional boundaries', including maintaining a professional relationship, feeling supported by colleagues, managing personal feelings, and wanting better care for their clients. However, the use of Content Analysis likely limited the depth of the findings (Vaismoradi, Turunen & Bondas, 2013), and it has been argued that it is important to investigate the experiences of nurses working in community mental health settings, as they frequently come in contact with clients who self-harm, and are in a key position to implement interventions (Thompson, Powis and Carradice, 2008b).

Thompson et al. (2008b) therefore utilised IPA to interpret community psychiatric nurses' descriptions of their experiences of working with clients who self-harm in the community. The nurses reported difficulties in conceptualising self-harm and managing the boundaries of their professional responsibilities in relation to managing risk. The nurses viewed the therapeutic relationship as crucial and described a variety of coping methods they used to manage the shock, sadness and disgust they experienced. The use of IPA resulted in a detailed understanding of the nurses' experiences. However, the study failed to consider the experiences of nurses working with adolescents who self-harm (Cleaver, 2014).

2.1.4. Rationale and Research Question

Overall, the small body of research qualitatively exploring professionals' experiences of working with adults who self-harm has proved informative (Fox, 2011). However, an under investigated area of study is nurses' experiences of working with adolescents who self-harm (Cleaver, 2014; Rissanen, Kylmä & Laukkanen, 2011). Nurses working with adolescents are likely to report different experiences, as adolescent self-harm is distinct from self-harm in adults (RCP, 2010) and adolescents are very different to adults in relation to their impulsivity, emotional dysregulation, risk factors and intent (Groschwitz & Plener, 2012; Hawton & Harriss, 2008).

Furthermore, the majority of previous research has focused on nurses working in inpatient settings (e.g., Lundegaard et al., 2012; Tofthagen et al., 2014). Due to the number of people who engage in self-harm within the community and the finding that the majority of individuals who self-harm do not present at hospitals (Fox & Hawton, 2004; McManus et al., 2016), further research exploring nurses' experiences in community settings, such as community CAMHS, is required (Timson et al., 2012).

To the author's knowledge, there have been no studies exploring CAMHS nurses' experiences of working with adolescents who self-harm in the community (Best, 2006; Timson et al., 2012). The present study aims to address this gap by adopting a qualitative methodology to gain an in-depth understanding of what it is like for nurses to work with adolescents who self-harm in the community. It is hoped that this increased understanding will offer important insights into the support and training needs of nurses working with adolescents who self-harm in community settings, to inform

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effective staff support systems and improve client care. The aim of this exploratory study is therefore to address the research question, '*What are CAMHS nurses' experiences of working with adolescents who self-harm in the community?*'.

2.2. Method

2.2.1. Design

The limited existing literature and research aim led to an interpretivist epistemological position, where knowledge is viewed as socially constructed and gained through an individual's interpretation of their experience of the social world (Ormston, Spencer, Barnard & Snape, 2014; Larkin & Thompson, 2012). Within this interpretivist epistemology, IPA was utilised for the data collection and analysis due to its phenomenological, interpretative and idiographic basis. IPA enabled an open, in-depth exploration of nurses' interpretations of their experiences and their meanings (Ormston et al., 2014), providing the opportunity for a more comprehensive understanding of this under-researched topic area. Additionally, phenomenological research has been recognised as a useful framework for capturing healthcare professionals' work-related experiences (Fade, 2004), and IPA has previously been used to explore nurses' experiences of working with clients who self-harm (Thompson et al., 2008b).

While approaches such as Grounded Theory may have provided interesting insights, IPA was deemed most appropriate due to the aim of understanding nurses' experiences, rather than understanding a construct or developing a new theoretical explanation. Moreover, the aim of understanding nurses' own phenomenological experiences and recognition of the influence of the researcher's own interpretations and

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assumptions further supported the use of IPA, due to its acknowledgement of dual-hermeneutics (Smith et al., 2009).

2.2.2. Participants and Recruitment

As is common in qualitative research, a non-probability design with purposive sampling was employed, where participants were selected based on availability and specific relevant characteristics (Shinebourne, 2011). This approach was chosen to facilitate a suitably homogenous sample for IPA (Smith et al., 2009). The main researcher presented the study at nursing meetings, and provided detailed information sheets with contact details (Appendix G). Nurses expressed their interest by emailing the researcher and interviews were scheduled if they met the inclusion and exclusion criteria detailed in Table 2.1.

Table 2.1. *Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria
Qualified nurses	Various professionals that are not qualified nurses
Working in community CAMHS in a West Midlands Trust	Working in other settings, such as A&E or inpatient, or other Trusts
Working with adolescents (11-17) who self-harm	
Experience of working with adolescents who self-harm within the previous 12 months	

Qualified Nurses were recruited, as evidence has shown that practices differ between different professional groups (Weston, 2003), and nurses tend to be the primary professional group who work with people who self-harm (Allen, 2007). Furthermore, only nurses working in Midlands' NHS Trusts were recruited to increase

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sample homogeneity, as nurses working in other, less ethnically diverse locations may have different experiences. Nurses working with adolescents (age 11-17) were included to ensure homogeneity, as experiences of working with adults or children are likely to be different. A specific length of experience was not specified, as length of experience has not been found to significantly impact nurses' attitudes and experiences (Wheatley & Austin-Payne, 2009). Nonetheless, recent experience, defined as within the last year, was required to ensure that the nurses were able to provide detailed accounts of their experiences.

In line with Smith et al.'s (2009) IPA recommendations, a practical and suitably homogenous sample of 10 nurses (8 women, *Age*=33 years; mean length of experience=6.5 years) from CAMHS in two Midlands' NHS Trusts was recruited. This sample size enabled the researcher to gain an in-depth understanding (Gilbert, 2001), and consider the similarities and differences between interviews (Smith et al., 2009). Participant characteristics are outlined in Table 2.2, with pseudonyms to protect participants' anonymity.

Table 2.2. *Participant characteristics*

Name†	Sex	Age	Ethnicity	Length of experience
John	M	55	White British	18 years
Phoebe	F	25	White British	2 years
Harpreet	F	28	White British	2.5 years
Jade	F	24	White British	1.5 years
Nala	F	24	White British	2.5 years
Ashanti	F	38	White British	5 years
Zane	M	40	Black African	4 years
Angela	F	49	White British	25 years
Sarah	F	24	White British	1.5 years
Amy	F	26	White British	3 years

Note. †= Pseudonyms utilised to ensure anonymity.

2.2.3. Ethical Considerations

Ethical approval was sought and gained from Coventry University and Health Research Authority (HRA) Ethics Committees prior to research beginning (Appendix H and I). Balancing the need for increased understanding of clinical phenomena, with participants' needs for privacy and safety can produce ethical dilemmas for researchers (Lloyd-Richardson et al., 2015). Consistent with the British Psychological Society (BPS) Code of Ethics and Conduct (2009) and Code of Human Ethics (2010) guidelines, the following ethical considerations were therefore considered and addressed:

2.2.3.1. Informed consent.

A detailed information sheet (Appendix J) was provided to all potential participants before informed consent was gained (Appendix K). This informed participants of their rights, the research process and aims, and the inclusion of verbatim extracts in published reports (Smith et al., 2009).

2.3.3.2. Privacy.

Consistent with the Data Protection Act, all identifiable information was kept confidential (BPS, 2009), with data stored securely, and all transcripts and reports anonymised through the removal of this identifiable information.

2.2.3.3. Harm.

Although it was not anticipated that the study would cause harm, consideration was given to the protection of participants, as talking about sensitive issues may constitute harm (Smith et al., 2009). Participants were debriefed about the range of

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sources of support they could access (Appendix L), and the researcher devised a protocol of how to manage concerns about participant well-being. During the study, one participant had what appeared to be scars from historic self-harm and presented as slightly distressed during the interview. The researcher subsequently paused the interview, checked in with the participant and reminded them that they could end the interview at anytime. The participant explained that they were okay and wished to continue the interview. At the end, the researcher reminded them again of the support options available.

2.2.4. Materials

Consistent with IPA methodology (Smith et al., 2009), a brief, flexible interview schedule (Appendix M) was utilised as a guide to allow greater flexibility and produce richer data (Smith & Osborn, 2006). The schedule was developed in accordance with the research aims and previous literature (Thompson et al., 2008b), and in consultation with supervisors, and nurses from the Trusts. The interview schedule began with demographic questions, to facilitate the establishment of a rapport. Questions were general (e.g. *“What is it like working with adolescents who self-harm?”*), with specific prompts if required (e.g. *“How do you think working with self-harm affects you?”*).

2.2.5. Procedure

One-to-one semi-structured interviews (SSIs) were deemed most appropriate for this study, as they enable adaptability to participant responses (Bell, 2010), and an open exploration of under-researched areas (Smith & Osborn, 2006). Furthermore, SSIs have also been informative in previous self-harm research using IPA (Thompson et al., 2008b). While the structured questionnaires utilised in previous research (Clever,

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2014) may be more time and resource economical, this inflexible approach results in answers that lack depth (Thompson et al., 2008b). SSIs allowed for the subjectivity of human experience and enabled a rich exploration of the nurses' experiences, subsequently producing more accurate data.

Participants were interviewed between April and July 2018. Prior to the interview participants were asked to re-examine the participant information sheet, and given time to ask questions or raise concerns. Written consent was then obtained and basic demographic information was gathered. The interviews were conducted in a private room at the nurses' CAMHS base and audio recorded, lasting between 42-70 minutes (mean of 54 minutes). After the interview a verbal and written debrief was provided, detailing support options.

2.2.6. Data Analysis

The audio-recorded interviews were transcribed verbatim and anonymised through the removal of any identifiable information. Figure 2.1 outlines Smith et al.'s (2009) iterative, cyclical procedure for IPA, which was utilised to analyse the transcripts, to increase access to the deeper reality of the nurses' experiences, from their perspective (Smith & Osbourn, 2006).

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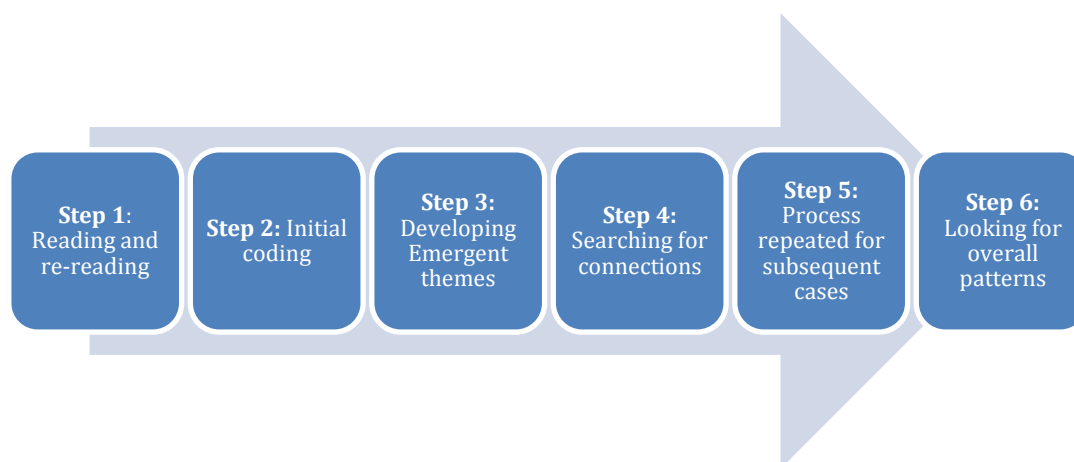


Figure 2.1. Smith, Flowers and Larkin's (2009) procedure for IPA.

The researcher re-read the individual transcripts in order to become immersed in the data and identify descriptive, linguistic and conceptual codes (see Appendix N for an example). Patterns of meaning (emergent themes) within each transcript were colour-coded, and cross comparison was conducted by identifying similarities and differences. Abstraction (Smith et al., 2009) was then used to cluster emergent themes into superordinate themes (see Appendix O for photos of the process). The distribution of participants' contribution to each theme is displayed in table 2.3.

Table 2.3. *A table illustrating participants' contributions to the themes.*

Superordinate theme	Personal and Professional Conflicts		Personal and Professional Development	
Subordinate theme	"keeping everyone happy"	"double-edged sword"	"I can switch off ... from being a professional, and be a person"	"it has got easier, just with experience"
John	✓	✓	✓	✓
Phoebe	✓	✓	✓	✓
Harpreet	✓	✓	✓	✓
Jade	✓	✓	✓	✓
Nala	✓	✓	✓	✓
Ashanti	✓	✓	✓	✓
Zane	✓	✓	✓	✓
Angela	✓	✓	✓	✓
Sarah	✓	✓	✓	✓
Amy	✓	✓	✓	✓

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2.2.6.1. Study credibility.

Numerous guidelines for qualitative research rigour have been published (e.g. O'Brien, Harris, Beckman, Reed & Cook, 2014). Multiple techniques were subsequently employed to ensure that the themes are warranted, accurate and grounded in the data, including auditing of codes and emergent themes within the research team, coding by an independent researcher, and respondent validation by the participants. All participants consented to respondent validation, and were given the opportunity to provide feedback on the themes, however, only one nurse provided feedback, validating the themes as an accurate representation.

2.2.4.2. Reflexivity.

The researcher, a Trainee Clinical Psychologist, had prior contact with both CAMHS teams due to previous placements within each team. This established relationship likely aided recruitment and the establishment of a rapport (National Research Ethics Service, 2013). Nonetheless, the researcher was aware that the nurses may have consciously or unconsciously adapted their responses or found it challenging to be honest due to a fear of professional judgement or of the researcher's expectations of them.

The dual-hermeneutic underpinning of IPA recognises that researchers experience participants' accounts of their experiences through a process of inter-subjective meaning making, subsequently enabling researchers impacts to be identified and embraced through reflection (Larkin & Thompson, 2012). A bracketing interview, reflexive log and reflective discussions with the supervisory team were subsequently utilised to facilitate the researchers' reflexivity and manage the risk of researcher bias

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(Bell, 2010). These processes enabled the researcher to consider the potential impact of their own experiences of working with adolescents who self-harm, and their tendency to fall into the Rescuer role within Karpman's (1968) Drama Triangle¹.

2.3. Findings

The aim of this research was to gain an understanding of nurses' experiences of working with adolescents who self-harm. This was achieved by analysing data in accordance with IPA, within an interpretivist approach. Verbatim quotations from participants were utilised to ensure the nurses' experiences were accurately expressed, and consideration was given to divergence and convergence within themes. Two superordinate themes emerged, each consisting of two subordinate themes, displayed in Table 2.4.

Table 2.4. *Superordinate and Subordinate Themes*

Superordinate theme	Subordinate themes
Personal and Professional Conflicts	a) <i>"keeping everyone happy"</i>
	b) <i>"double-edged sword"</i>
Personal and Professional Development	a) <i>"I can switch off ... from being a professional, and be a person"</i>
	b) <i>"it has got easier, just with experience"</i>

2.3.1. Superordinate Theme 1: Personal and Professional Conflicts

All nurses communicated experiences of personal and professional conflicts throughout their work with adolescents who self-harm. They described experiences of

¹ Karpman's (1968) *Drama Triangle* is a psychoanalytic model of personal responsibility and power in interpersonal interactions, derived from Transactional Analysis (Berne, 1964). The inverted triangle demonstrates three destructive roles, or 83 faces of drama that people can play in conflict: the Persecutor, Rescuer and Victim.

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conflictual emotions and expectations of themselves. They also appeared to experience shame in response to viewing themselves as either too detached or too attached to, and emotionally impacted by, the adolescents and their systems. These conflicts appeared to be particularly evident in the context of working with adolescents who self-harm, due to the unpredictable nature of self-harm, and an increased need to work with the systems around the adolescents and consider both the adolescents' mental health and physical health. This theme subsequently encompasses subthemes relating to conflicts within interpersonal interactions "*keeping everyone happy*" (Sarah, 240²) and intrapersonal experiences "*double-edged sword*" (Amy, 2).

2.3.1.1. Subordinate theme 1a: "keeping everyone happy".

All nurses described personal and professional conflicts throughout their interpersonal interactions with the systems around the adolescents. These appeared to be exacerbated in the context of working with adolescents who self-harm, due to the increased need to work with families and other services. They communicated the conflict of balancing prioritising the needs of the adolescent who is self-harming, whilst recognising the importance of working with the different people in the adolescents' system:

"those sorts of situations are so emotionally draining, because you've got to have in a way, both feet in both worlds ... you need to be there for the young person, but you can't alienate the parents" (John, 444-446).

The conflicts and systemic working appeared to be particularly prevalent in the community CAMHS context, due to the adolescents living at home with their families, who were therefore seen as sharing the risk and responsibility:

² Numbers refer to line numbers from participant transcripts.

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“It’s a relief as you know you’re going to be able to do collaborative work with the parents. I only see a child once a week, they are at home with the child.”
(Nala, 73-74).

Mixed experiences of working with the systems around the adolescents, including families, schools, A&E and social services were evident in all of the nurses’ accounts:

“You get some families who are very supportive, who will do everything and anything ... And then you get some families and they are harder to work with”
(Sarah, 177-181).

The nurses appeared to feel conflicted when working with systems, as they often experienced frustration and increased pressure and responsibility due to unreasonable expectations, unhelpful responses and a lack of understanding from others:

“some parents think that you have a magic wand and can stop the self-harming overnight. Some parents don’t understand it and will punish the young person ... and that actually exacerbates the problem” (Phoebe, 165-168).

At the same time, the nurses also expressed empathy and understanding for families and services. They recognised how distressing and challenging it must be to understand and manage self-harm given how counterintuitive self-harm can seem, the risk associated with it, and the additional demands and lack of training they have:

“If you put yourself in their shoes, you can see it. They have a really poorly adolescent who is really self-harming, they feel stuck” (Amy, 441-443).

Furthermore, most nurses identified that while working with systems can be challenging, it enabled them to make more of a difference, and could lead to better outcomes:

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“you probably get better outcomes, longer term, if you can shift the systemic thinking” (Harpreet, 96-97).

Additionally, many nurses identified the benefits of dual working and liaising with other services, such as iCAMHS, a specialist intensive support service for young people in crisis, when working with adolescents who self-harm. Due to the risky nature of self-harm, dual working helped to reduce the nurses' anxiety and enabled them to focus on the therapeutic work instead of risk management:

“it takes off so much pressure iCAMHS doing that management ... whilst you can carry on doing other work” (Angela, 348-351).

2.3.1.2. Subordinate theme 1b: “double-edged sword”.

Nurses expressed personal and professional conflicts regarding their intrapersonal experiences; often because of the responsibility they felt due to the expectations they have of themselves, and the competing demands they have to manage. They described feeling personally responsible for the adolescents and their progress, subsequently feeling proud and confident when adolescents are progressing, and like they have “*failed*” (Angela, 186) when adolescents regress. This was particularly challenging due to the unpredictable and uncontrollable nature of self-harm:

“you get that kind of rollercoaster recovery, you get to that place where you think “ohh, they’re doing alright”, then they do something and it seems to come crashing down.” (John, 210-211).

As a consequence, the nurses described subsequently feeling conflicted about the adolescents themselves, feeling frustrated at them due to the lack of progress, but also empathising with them and feeling sad that the young person saw no other option.

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They experienced self-harm as a “*double-edged sword*” (Amy, 2), finding the work challenging, frustrating and stressful, but also rewarding and enjoyable:

“It is a huge responsibility and a huge honour to work with people when they are so vulnerable.” (Harpreet, 525-526).

Most nurses also expressed conflicts about their emotional responses to this “*rollercoaster recovery*” (John, 210) evident in adolescents who self-harm. While they recognised that the emotional investment can at times improve their understanding and practice, there was a sense that they felt ashamed of feeling anger towards the adolescents for self-harming, feeling responsible or taking self-harm personally, as they believed that they should not get emotionally involved:

“you take it personally. I mean you’re not supposed to, but you can’t help it. You feel like you’ve let them down” (Phoebe, 10-11).

Service pressures, such as large caseloads appeared to add to the conflicts and shame the nurses experienced as they felt they should provide more or better care for adolescents who self-harm. They described feeling torn when adolescents self-harm, experiencing sadness and empathy for the adolescent, but also frustration and stress due to their increased workload:

“you feel for them, and then on the other hand you’re like “you’re having a laugh, come on” and when am I going to be able to sort this?” (Ashanti, 288-289).

In contrast to the experiences of shame due to being too emotionally involved, when describing situations where they have experienced these conflicts, the nurses often appeared ashamed of not caring enough, or being too emotionally detached:

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“When she is admitted ... there is a big weight off my workload, and I know that is awful, but it’s the truth.” (Phoebe, 322-324).

Another common conflict was the difficulty of managing both the physical health and risk associated with self-harm, as well as the underlying mental health:

“you’ve got the difficulty of the mental health side of things, in terms of why they are self-harming and what it is they are getting out of self-harming. And also the physical health side that you’ve got to be aware of ... It can be quite stressful and quite daunting.” (Amy, 6-10).

Most nurses experienced a professional conflict due to feeling responsible for addressing the risk element as a priority, which interfered with their goal of addressing the mental health issues underlying the self-harm:

“Forget the mental health, if they’re going to be dead next week” (Harpreet, 382)
“it is very hard to actually get beyond that, which is where I like to work” (Angela, 66-67).

These conflicts around risk management and responsibility appeared to be exacerbated by the lone working often present in community CAMHS. The nurses described experiencing increased anxiety due to the adolescents not being constantly monitored as they would be in inpatient settings, and feeling isolated in community settings:

“it can feel quite lonely when you’ve got a really risky young person and you’re the only one initially involved with them, and sometimes it can feel that you’ve got their life in your hands” (Ashanti, 369-370)

Nurses also described the importance of the therapeutic relationship, and the personal and professional conflicts they experienced as a result of it. Most nurses

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explained how the therapeutic relationship could lead to conflicted feelings about their professional boundaries and becoming personally attached:

“it can be very very difficult to figure out where the boundaries are between I am still a professional in this person’s life, I am not a friend” (Harpreet, 119-120).

When nurses expressed personal conflicts about this *“blurring the lines”* (Phoebe, 344-345), there was a sense of shame about becoming too emotionally involved. They explained that they should not become attached, but recognised that sometimes it was inevitable:

“we human beings, sometimes as professionals we can be attached to cases, you know, we try not to, but it does happen” (Zane, 252-252).

Additionally, some nurses reported subsequent experiences of feeling conflicted when discharging adolescents, feeling happy about the progress they had made, but also sad about the work coming to an end:

“there was relief that we’d got this young person to a point that she didn’t feel that she needed community services ... but again the sadness can creep in at that time as you’ve come on such a journey with that young person.” (Amy, 270-275).

These conflictual experiences were exacerbated by service policies, including policies to discharge at age 17 and increase *“the throughput of people”* (John, 239), which increased experiences of frustration when nurses felt that adolescents required more input:

“that isn’t why I came into nursing, to go oh well you have turned 17 so you have to move on to something else, even though you have been working really hard” (Jade, 308-309).

2.3.2. Superordinate Theme 2: Personal and Professional Development

This theme encompasses subthemes describing the ways nurses have learnt to manage the conflicts and difficult emotions they experience, *“I can switch off ... from being a professional, and be a person”* (Harpreet, 192-193), and the overall process of development they have gone through, *“it has got easier, just with experience”* (Sarah, 83-84).

2.3.2.1. Subordinate theme 2a: “I can switch off ... from being a professional, and be a person”.

The nurses described needing to tolerate the conflicts and manage their emotions, for the adolescents and families they work with:

“if you’re anxious about them, you’re not containing. Once you’re seen to be a container that can absorb all this, at that point, that is when you become really helpful to them” (John, 33-36).

Some nurses also recognised the importance for their own families, and themselves, although there was a sense of conflict and shame about this. The nurses appeared to be ashamed of not caring enough for the adolescents by prioritising their own well-being, but recognised that it was necessary for their own self-care:

“As much as I would like to do more for people ... I am one person and my own well-being and the well-being of my family has to come first, otherwise I wouldn’t be at work at all. Sometimes I feel sad thinking that way, but actually, if I didn’t, I wouldn’t be here, I’d be off sick” (Harpreet, 438-441).

All nurses explained that they coped by finding ways to switch off from being a professional, including having breaks and having a laugh with colleagues in work, and separating their work and home lives, by doing things they enjoy to distract themselves after work:

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*“you have to kind of laugh in the face of adversity” (Ashanti, 299).
“I then walk the dog, have a bath, do my thing, I can then switch off” (Phoebe, 381).*

Similarly, in the interview the nurses appeared to detach and switch off when they spoke about emotionally challenging aspects of the job, as they began speaking in the third person, or about nurses in general:

“You know, emotionally as a human being, you feel that you are putting much effort in” (Zane, 50-51).

Moreover, the nurses described managing the difficult emotions and conflicts by seeking advice and reassurance from colleagues and supervisors, and sharing the responsibility. They identified how these formal and informal discussions could help them clinically and emotionally. However, many nurses felt that the emotional support was more useful than clinical guidance:

“Sometimes you don’t need an answer; you just need to talk through it, to get it off your chest” (Sarah, 327).

As well as seeking reassurance from colleagues, the nurses described various ways of validating themselves, such as accepting their limitations and the limits to their responsibility:

“Ultimately, you have to realise that it’s not your fault, or the CAMHS service, sometimes mental illness is horrible and young people can be very poorly” (Amy, 369-370).

Some nurses described challenging their self-doubt by reflecting on positive outcomes, and positively reframing their experiences, by seeing difficult times as an opportunity to understand, learn and become more motivated:

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“you try and think about, well that is working, so maybe there is something specific about this case, rather than I’m just a crap nurse” (Nala, 348-349)
“it’s a pressure, but a pressure that you can use in a positive way to make you feel more determined and more engaged” (Jade, 300-301).

During the interviews, the nurses appeared to be using many of these techniques. For example, the nurses normalised the self-doubt they experience and validated themselves by expressing how challenging the work is and the complexity of cases:

“it’s never a straightforward piece of work, and that can be frustrating, but unfortunately that’s CAMHS” (Ashanti, 199-200).

All nurses also appeared to be positively reframing their experiences as they spoke and counteracting the challenging aspects by explaining that many adolescents do progress, and reflecting on how meaningful and rewarding the job is for them:

“It’s okay to feel those emotions, because for me, it informs my work and motivates me” (Amy, 83-84)
“it’s made me unwell, physically and emotionally unwell. But then, they’re the young people that I want to work with” (Phoebe, 66-67).

Most nurses explained that despite these strategies, they continued to experience some anxiety and found it difficult to switch off at times:

“if there is something really on your mind you can do those things and it will still pop up” (Angela, 116-117).

This was at times due to not having the time to use their coping strategies, feeling that their colleagues were too busy, or prioritising the adolescents over their own self-care:

“Finding the space, and prioritising that, that can be hard, because someone needs an appointment” (Sarah, 334-335).

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2.3.2.2. Subordinate theme 2b: “it has got easier, just with experience”.

As well as learning ways to cope with the conflicts they experience, the nurses described the process of development that they have been through working with adolescents who self-harm and their families. They described experiencing overwhelming anxiety and low confidence when they began working with adolescents who self-harm in the community, due to a lack of prior training or experience:

“the risk appears higher when you first start working in the field, because you have nothing to base it on. Nothing in life prepares you for working with self-harm” (John, 58-60).

Following this initial anxiety, nurses described a process of learning on the job, gaining increased confidence and understanding through the experience of working with the adolescents:

“you come out the other side, with supervision, with support, with the parents on-board, with the young person, and grow as a clinician” (Nala, 250-251).

They described feeling less overwhelmed and more able to tolerate the risk, uncertainty and difficult emotions over time:

“you still go through that rollercoaster of emotions with them, but your resilience starts to grow after a couple of years think” (Phoebe, 52-53).

The nurses appeared to feel quite conflicted about the emotional de-sensitisation they experienced, through the process of being exposed to severe self-harm. There was a sense of shame about being less emotionally affected, although they recognised that it was normal and necessary, as it enabled them to think more rationally, be less emotionally involved and continue to do their job effectively:

“I feel awful saying that, as if I’ve become hardened to it” (Amy, 106-107)

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“you do become desensitised with stuff, and you have to be to manage and to cope” (Harpreet, 107).

As well as learning from working with the adolescents, most nurses identified that a significant part of their development was due to learning from their colleagues and attending training. They described their experiences of the benefit of working within a multi-disciplinary team, who can provide support and a range of different perspectives, enabling the nurses to gain a more in-depth, sophisticated understanding of self-harm, and a wider variety of approaches to address it:

“that is the most valuable tool we’ve got, each other’s experiences, and different ways we all manage things” (Harpreet, 504-505).

Many nurses who had attended self-harm training and therapeutic training reflected on how it increased their confidence in understanding, assess and managing self-harm. However, some felt that there was not enough training:

“It’s good, but probably not regular enough. STORM was good as it is more of an in-depth risk assessment, and it makes you feel more confident” (Phoebe, 415-416).

2.4. Discussion

The present study was the first to explore nurses’ experiences of working with adolescents who self-harm in the community. This exploration was intended to increase understanding of nurses’ experiences and subsequently inform clinical support. The findings are now discussed within the context of existing literature. Subsequent clinical implications, study limitations and directions for future research will also be addressed.

2.4.1. Discussion of Findings

2.4.1.1. Personal and professional conflicts.

Notably, the experience of personal and professional conflicts was prevalent for nurses throughout their work with adolescents who self-harm. While the overarching experience of conflicts was novel, aspects of the conflicts described have been identified in previous research exploring nurses' experiences of working with adults who self-harm. For example, the conflictual experiences of maintaining professional boundaries with clients, and managing personal feelings of responsibility and professional responsibility to manage risk have previously been identified (Thompson et al., 2008b; Tofthagen et al., 2014; Wilstrand et al., 2007). Similarly, nurses in the present study appeared to feel pressure and responsibility to manage risk and ensure the adolescents' safety, which is emphasised within the nursing code of conduct (Nursing and Midwifery Council [NMC], 2018).

Furthermore, there was a divergence in experiences regarding professional boundaries, and a sense of conflict and shame about the personal responsibility nurses felt and the attachments they built with adolescents. Many nurses appeared to feel ashamed of being more emotionally involved than they felt they 'should' be as a professional and appearing to not cope, or to cross professional boundaries. For example, *"you take it personally. I mean you're not supposed to, but you can't help it"* (Phoebe, 10-11).

On the other hand, the nurses also appeared to be conflicted and ashamed of, at times, staying in a more professional and detached position, and not being as caring and compassionate as they felt they 'should' be as a nurse, which is also emphasised as

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necessary within the nursing code of conduct (NMC, 2018). For example, there was a sense of shame about appearing uncaring due to the relief they experienced when they had some respite from their workload, "*When she is admitted... there is a big weight off my workload, and I know that is awful, but it's the truth*" (Phoebe, 322-324). The nurses therefore appeared to be in a double bind, where they experienced shame for being either too emotionally involved, or too detached and uncaring.

Building upon previous research (Fox, 2011), the conflicts and shame appeared to be exacerbated by service restraints, which were incongruent with the nurses' expectations of themselves. Nurses need time and resources to build therapeutic relationships and offer high-quality care for people who self-harm (Karman et al., 2015). Service restraints, such as high caseloads and pressures to discharge due to inadequate provisions, are common in community CAMHS (BPS, 2015), subsequently negatively impact the care nurses can provide (Karman et al., 2015). These experiences of shame extend upon previous research, and can be explained by the concept of moral injury; defined as the lasting psychological sequelae, of taking, failing to prevent, or witnessing an action that directly violates one's moral beliefs and values (Litz et al., 2009; Shay, 2014). Initially used to understand presentations in war veterans, moral injury is a relatively new concept that has been applied to understand the experiences of healthcare professionals as a result of providing inadequate care due to service restraints (Murray, Krahé & Goodman, 2018). This suggests that some of the shame the nurses experienced was a consequence of a moral injurious conflict of providing care they perceived as insufficient (Litz et al., 2009; Shay, 2011). Overall, the conflicts and shame experienced appeared to contribute to the challenge of working with adolescents who self-harm.

Additionally, the “*rollercoaster of emotions*” (Phoebe, 52) described by nurses in the present study supports previously recognised themes regarding the emotional impact, and nurses experiencing self-harm as challenging, unpredictable and rewarding (Thompson et al., 2008b; Tofthagen et al., 2014; Wilstrand et al., 2007). Previous research has recognised the challenge of working with distressed adolescents and emotionally overwhelmed families (Gehring, Widmer, Bänziger & Marti, 2002). Despite these challenges, many nurses in the current and previous studies described the job as rewarding, as contributing to adolescents’ progress was meaningful for them, and led to feelings of pride, confidence and enjoyment. Nonetheless, these conflicts and emotional impacts need to be considered, as staff stress and well-being has been associated with families’ experience of care, and staff sickness and retention (Care Quality Commission, 2011).

Furthermore, conflicts relating to interpersonal interactions appear to be a novel finding particularly relevant to nurses working with adolescents who self-harm, as it has not been identified in research exploring nurses’ experiences of working with adults who self-harm. This may be due to adolescents being treated in the context of their systems (The Child & Family Clinical Psychology Review, 2015), and the recognised role of family as risk or protective factors for adolescent self-harm (Fortune, Cottrell & Fife, 2016; World Health Organization, 2012). Research has demonstrated the importance of CAMHS nurses working collaboratively with adolescents’ systems³, as interventions involving families or systems are best practice, and result in greater progress (Fonagy et al., 2015; BPS, 2015). The current study subsequently builds on

³ *Adolescents’ systems* refers to the people and services that are involved with the adolescents, who nurses are subsequently likely to liaise and work with. These include the adolescents’ family or carers, social care and other healthcare services.

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previous research, as it is the first qualitative study that has begun to explore CAMHS nurses' experiences of personal and professional conflicts within interpersonal interactions.

2.3.1.2. Personal and professional development.

The nurses described a range of techniques to manage the personal and professional conflicts they experienced. The pressure nurses are under, and the subsequent need to find ways to cope has been well recognised (Kravits, McAllister-Black, Grant & Kirk, 2010; Lambert & Lambert, 2008). As previous research exploring nurses' experiences of working with adults who self-harm found, the nurses described utilising supervision and informal support to deal with their experiences (Thompson et al., 2008b). These findings add to research demonstrating the importance of supportive teams, as nurses who feel unsupported are more burdened by feelings (Wilstrand et al., 2007), and professionals who receive compassionate responses feel better able to recover (Abedini et al., 2018). The nurses also all described finding ways to switch off; including laughing with colleagues and distracting themselves outside of work. However, there was divergence in accounts, with some nurses explaining that despite these strategies, they continued to experience anxiety and often found it difficult to switch off.

The strategies nurses described and appeared to be using to challenge their self-doubt in the interview were novel in the context of previous research (Wilstrand et al., 2007). The strategies included validating themselves, accepting their limitations and positively reframing their experiences. These strategies may be examples of nurses

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applying therapeutic methods to themselves to manage their own emotions, which is encouraged by many therapeutic models (e.g. Harris, 2009).

Moreover, the experiences of development by gaining confidence and understanding, becoming de-sensitised and learning on the job due to a lack of previous training are consistent with the experiences described by nurses working with adults who self-harm (Thompson et al., 2008b). Similar to previous research (Carter et al., 2018), amassing experience of working with adolescents who self-harm appears to increase nurses' confidence in working with self-harm, and their understanding of self-harm, subsequently reducing the anxiety they experience. Additionally, the reduction of anxiety through becoming de-sensitised appears to be a necessary self-protective strategy for nurses working with people who self-harm (Thompson et al., 2008b; Wilstrand et al., 2007).

The shame nurses appeared to feel as a result of de-sensitising and prioritising their own self-care were novel findings. Similar to the sense of shame identified when nurses expressed relief due to a reduction in workload when a young person was admitted into hospital, the nurses appeared to feel ashamed of not being as emotionally involved as they felt they 'should' be, and appearing uncaring or detached. For example, "*I feel awful saying that, as if I've become hardened to it*" (Amy, 106-107). Additionally, there was a sense of shame when some nurses described prioritising their own well-being, for example "*my own well-being and the well-being of my family has to come first... Sometimes I feel sad thinking that way*" (Harpreet, 439-440). There was a subsequent divergence in reactions, as whilst the nurses described accepting their need to cope and switch off, some nurses explained that they struggle to find time for

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supervision and breaks, due to feeling that they should prioritise offering the adolescents appointments. This demonstrates the previously recognised challenge of self-care for nurses (Burkhardt & Nagai-Jacobson, 2001), and a potential lack of self-compassion (Gilbert, 2009).

Furthermore, the lack of training is an important finding, as previous research exploring nurses attitudes has demonstrated that limited training and education are fundamental factors in the development and maintenance of negative attitudes towards self-harm (Karman et al., 2015; Rayner, Blackburn, Edward, Stephenson & Ousey, 2019). Additionally, consistent with previous intervention studies, some nurses in the present study felt that training improved their understanding of self-harm and confidence in working with adolescents who self-harm (Patterson, Whittington & Blogg, 2007). This study subsequently adds to the general consensus that nurses working with people who self-harm require more training (e.g. Cleaver, 2014; Carter et al., 2018; Timson et al., 2012).

2.4.2. Clinical Implications

2.4.2.1. Professional training and practice recommendations.

Given the reported experiences of isolation and benefits of shared responsibility, joint working is recommended for nurses working with adolescents who self-harm. This could be with colleagues within the service, or related services, such as the specialist iCAMHS intensive support service described by some participants. Joint working has been identified as a key component of best practice (BPS, 2015), and may enable nurses to feel more supported, learn from colleagues, and separately address the risk and underlying mental health. Furthermore, the impact of the service restraints indicates that

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CAMHS should ensure that nurses have the time and resources to work closely with adolescents who self-harm and their families. These recommendations will likely reduce the pressure nurses experience, and improve the care they provide (Karman et al., 2015).

The finding that nurses lacked confidence in working with adolescents who self-harm and lacked a comprehensive understanding of self-harm due to limited training demonstrates the need for more training for nurses to understand and manage self-harm. This could be drawn from previous educational interventions that have improved nurses' attitudes towards individuals who self-harm, their understanding of self-harm and their confidence in working with individuals who self-harm (e.g. Holdsworth, Belshaw & Murray, 2001; Patterson et al., 2007). Additionally, specific training or supervision from trained professionals regarding evidence-based therapeutic interventions for managing self-harm and the mental health issues underlying it, including Dialectical Behaviour Therapy, Mentalisation-based Therapy, and Cognitive Behavioural Therapy (Ougrin, Tranah, Stahl, Moran & Asarnow, 2015), is recommended. This would likely improve nurses' work satisfaction and confidence in working with adolescents who self-harm, as well as improving clinical outcomes, such as decreased rates of self-harm repetition (Karman et al., 2015). Moreover, supervision or training in systemic approaches and relational models, such as Cognitive Analytic Therapy and Psychodynamic approaches is recommended to enhance nurses confidence in formulating self-harm, working with systems around adolescents, and recognising patterns of relating, transference and countertransference (Brent et al., 2013; Sheard et al., 2000; Thompson, Donnison, Warnock-Parkes, Turpin & Kerr, 2008a). These recommendations are consistent with NICE guidelines (2004), which state that

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professionals working with people who self-harm should receive appropriate supervision and training, and The 5 Year Forward plan (The Mental Health Taskforce, 2016) to invest in training to ensure professionals working in CAMHS know how to assess and work with mental health difficulties.

2.4.2.2. Personal support and training recommendations.

With regards to the personal emotional impacts and the potential moral injury experienced, it is important for self-care to be encouraged within CAMHS. The importance of staff support and training for coping with stress is well established (Fang & Li, 2015; Watson et al., 2009). Given the self-criticism and shame nurses appeared to experience, training or supervision from a therapeutic model that addresses this, such as Compassion Focussed Therapy (CFT; Gilbert, 2009), is recommended for CAMHS nurses. Clinical Psychologists or other CFT trained professionals within CAMHS teams could provide this, to help nurses understand their emotional regulation systems and develop self-compassion. Furthermore, some nurses described struggling to find time to use the support and distraction strategies they found helpful. It would therefore be useful to encourage mutual support and allocate time in nurses' job plans for breaks and regular mandatory support systems.

Finally, the conflicts experienced often resulted from nurses feeling ashamed of being too detached, or too personally involved with the adolescents and the people in the adolescents' system. Reflective practice sessions and supervision opportunities are therefore recommended to facilitate open discussions regarding the conflicts nurses experience and normalise their experiences of de-sensitisation. It would also be useful for nursing training and CAMHS to provide guidance on how to recognise and

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appropriately manage the personal aspects of the self, and information regarding the recognised benefits of the use of self and attachments in therapeutic interventions (Obegi, 2008; Peloquin, 2005; Taylor, Lee, Kielhofner & Ketkar, 2009). These sessions would validate nurses, reduce their anxiety and shame, and enable them to use the personal aspects of themselves more effectively within therapeutic relationships.

2.4.3. Limitations and Future Research

Steps were taken to ensure that the results of this study were as valid as possible. Nonetheless, there were limitations that should be considered. Firstly, while the exclusion of nurses working in other CAMHS settings, such as Learning Disability (LD) or inpatient CAMHS increased the homogeneity of the sample, nurses working in these settings were not given the opportunity to express their experiences. Future research exploring these experiences would be beneficial, as self-harm in LD populations often has different functions (Summers et al., 2017), and nurses' experiences of working with adults who self-harm in the community differ from nurses' experiences in inpatient settings (Thompson et al., 2008b; Tofthagen et al., 2014).

Moreover, the nurses had all been qualified for at least 1 year, and were mostly female, White and British. These characteristics may have impacted the nurses' responses. Wheatley and Austin-Payne (2009) found that although unqualified nursing staff reported more negativity and anxiety than qualified staff, length of work experience was not a significant factor. However, findings concerning gender are inconclusive (Karman et al., 2015). Further studies exploring the experiences of other ethnic groups and male nurses are therefore recommended.

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Finally, given that the conflicts in interpersonal working were a novel finding, this may not have been explored in sufficient depth. Further exploration of nurses' experiences of working with systems in a range of CAMHS settings, would therefore be useful to gain a more in-depth understanding of the nurses' experiences. It may also be useful to interview other professional groups working in the community, to explore whether they describe conflicts similar to those experienced by the nurses. Examining these factors could make education and support interventions more personalised and effective.

2.5. Conclusion

In conclusion, despite these limitations, the study has provided insights into an important, and under-researched area. The use of an interpretative idiographic approach enabled the complexity of the nurses' experiences to be explored in detail. The study has demonstrated the personal and professional conflicts that nurses working with adolescents who self-harm experience, and how they learn to cope with these conflicts and develop as a person and a professional through working with the adolescents. This research has increased understanding of nurses' experiences, and identified ways to help nurses manage and reduce the conflicts they experience, both personally and professionally. It is hoped that the findings and implications will be considered by community CAMHS leads, and subsequently improve support and training for nurses working with adolescents who self-harm.

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Chapter 3: Reflective Paper

Reflection on Experiences of Learning to be a Person, a Clinician and a Researcher.

Overall chapter word count (exclusive of references and figures): 3893

3.1. Introduction

This chapter presents a reflective account of my experience of conducting research exploring adolescent self-harm. I reflect on my experiences of conducting research with nurses regarding their experiences of working with adolescents who self-harm, as well as conducting a systematic literature review exploring adolescents' experiences of self-harm. I will begin by considering the value of reflective practice, and reflexivity within the research process, and reflecting on my position as a researcher. Using Kolb's (1984) Experiential Learning Cycle, I will then reflect on my experiences throughout the research process, and my development towards becoming a qualified Clinical Psychologist. My reflections are ordered around the themes identified within my empirical study, as I felt my experiences paralleled many of the experiences the participants described.

3.1.1. Reflection and Reflexivity

Reflection has been recognised as a fundamental skill for trainee Clinical Psychologists (Division of Clinical Psychology, 2010), and is a skill I have utilised and developed throughout my training. Reflection, or 'reflection-on-action', is defined as a process of critical self-inquiry that facilitates learning from previous experiences (Jasper, 2003). It enables evaluation of practice and self-awareness, which fosters increased skills, knowledge and confidence (Bassott, 2016). I particularly value reflection, as in my clinical work, it has enabled me to understand and recognise my own emotional responses, thoughts and reactions to clients (conceptualised in Psychodynamic models as counter-transference), and the impact this may have on my clinical work. Within the research process, I found it particularly useful to retrospectively reflect on my experience of the interviews, and use this to aid my

understanding and analysis.

Parallel to the use of retrospective ‘reflection-on-action’, reflexivity, or ‘reflection-in-action’, is the process of continual self-appraisal that has been increasingly recognised as vital in qualitative research (D’Cruz et al., 2007). Reflexivity is an ‘in the moment’, critical approach to the generation of knowledge, where the reflexive researcher is constantly questioning and monitoring their own and others’ knowledge, relations and power (Berger, 2015). Consistent with the Interpretative Phenomenological Analysis (IPA) methodology I used, reflexivity recognises that knowledge is not objective, and that knowledge production cannot be independent of the researcher producing it, as the researcher’s actions and decisions will inevitably impact upon the meaning of the experience investigated (Horsburgh, 2003). I therefore used reflexivity throughout the research process, to continually consider my position, biases and personal experiences, and acknowledge the impact that these may have been having on the research process and outcome. Conducting this research has demonstrated to me how useful reflective practice (including reflection and reflexivity) is when conducting qualitative research, as it greatly enhanced my research practice.

3.1.2. My position

Reflecting on my position I considered personal characteristics that may have impacted my research, such as my age, gender, education, culture, ethnicity, beliefs, experiences, employment status, and ideological stance.

3.1.2.1. A trainee clinical psychologist.

My skills and training as a trainee Clinical Psychologist enabled me to quickly build a rapport with participants, enabling them to open up about their experiences. I reflected on the similarity between the interviews and the clinical assessments I conduct with clients, in which clients are expected to open up about personal experiences with me, someone they have never met before, and the power dynamic my title and role can cause. I was therefore mindful of the pressure the nurses may feel, and the potential power dynamics within the interview. I also felt privileged that the nurses chose to open up to me about such personal experiences, and motivated to ensure I created something of value, which could be published and disseminated.

My experience of being younger than many of the participants paralleled my experience of being the youngest trainee in my cohort. At times I felt inexperienced and recognised self-critical thoughts during the interview and transcription. Identifying these thoughts enabled me to challenge them and be more self-compassionate. It also helped me recognise a feeling of admiration that I had for some of the more experienced nurses, which may have influenced my analysis and the power dynamic in the interview. Furthermore, this experience enabled me to identify with the younger, less experienced nurses, who reported similar experiences of feeling inexperienced and being self-critical. However, I was mindful of not over-identifying with them and assuming that I understood their experiences.

3.1.2.2. A “partial insider”.

My position as a trainee who had worked in both teams likely aided my recruitment and interview process, as the nurses probably felt more willing to share

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their experiences with a researcher they perceived as sympathetic to their experiences. Additionally, considering the privileges I embody (e.g., White, higher education, cis-gender, middle class), I identified how sharing these privileged identities with most participants contributed to my 'partial-insider' position. Being a "partial insider" in this way enabled me to have more insight into the nurses' emotional realities and contexts, enhancing my ability to collect and interpret rich data (Chavez, 2008). Nonetheless, I was mindful of not over-relating and making assumptions based on my own experiences. Furthermore, I was aware of how being an "outsider" with respect to not being a nurse may have limited my understanding of the meaning they made from their experiences, and may have increased their fear of professional judgment, subsequently reducing their honesty.

3.1.2.3. A researcher.

With regards to my position as a researcher, I considered my epistemological position. I believe that my interest in helping other people by understanding their experiences and the meaning they make of them underlies my desire to be a Clinical Psychologist. Similarly, upon reflection, I believe that this led me to a more interpretivist position, subsequently guiding me towards areas of enquiry that required qualitative approaches for both my literature review and empirical study. Although I found the process of IPA complicated at times, I felt that the approach was largely consistent with my approach to understanding people.

Furthermore, I also considered my motivation for researching adolescent self-harm, and more specifically, nurses' experiences. Having worked with nurses in CAMHS, I became aware of the high levels of stress and pressure they experience, and

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lack of training many of them have regarding mental health, and self-harm in particular.

Reflecting on my own experiences of three years of teaching on my doctorate, as well as frequent supervision and a reduced caseload, I wanted to gain an understanding of their experiences, and hopefully identify ways to potentially improve them.

Interestingly, I later identified that my motivation may have in part been due to my desire to help people, and my tendency to be pulled into the Rescuer role within Karpman's (1968) Drama Triangle. With regards to adolescent self-harm, I initially wanted to explore the area due to the high prevalence in CAMHS, and my subsequent desire to gain an in-depth understanding of self-harm to aid my clinical practice.

However, on a deeper level, reflecting on my own experiences of working with adolescents who self-harm, I identified that part of my motivation was to gain more confidence in working with self-harm.

3.1.3. Kolb's (1984) Reflective Cycle

Within my reflexive log, I used Kolb's (1984) Experiential Learning Cycle (see Figure 3.1) to structure my reflections, as I have previously found this a helpful model for increasing my self-awareness and development. Within this cycle (Bassot, 2016), understanding, learning and development are facilitated through four stages: *Concrete Experience* (recognising an experience), *Reflective Observation* (reflecting on the experience), *Abstract Conceptualisation* (learning from the experience) and *Active Experimentation* (actioning the learning).

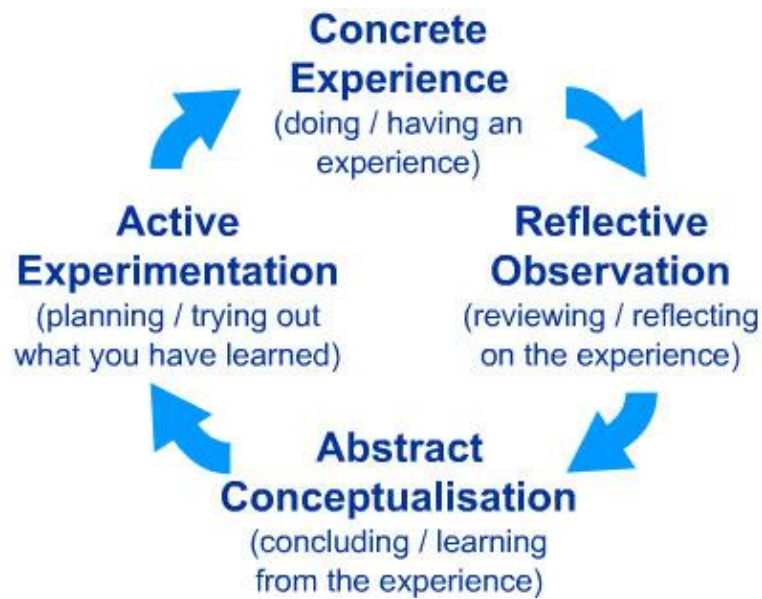


Figure 3.1. Kolb's (1984) Experiential Learning Cycle from Bassot (2016).

3.2. Personal and Professional Conflicts

3.2.1. "keeping everyone happy"

3.2.1.1. Concrete experience.

With regards to my experience of conflicts within interpersonal interactions, I was frequently aware of doubting my decisions and feeling frustrated due to receiving contrasting advice from colleagues and different university lecturers. I subsequently became indecisive due to a conflict within myself, as I felt I needed to follow all the advice I was given, but also felt a desire to do what I felt was correct, or had agreed with my research team. Demonstrating this, one of my reflective journal entries read, "*I want to do what is right, but don't know what that is*". This caused me to feel anxious as I felt a pressure to write the 'correct way', for my thesis to be good enough to be assigned a pass, and be publishable.

3.2.1.2. Reflective observation.

Reflecting on this experience enabled me to recognise my people pleasing tendency was resulting in me struggling to go against the advice I had been given. As a consequence, rather than being helpful, seeking additional advice caused me more anxiety and resulted in me doubting my research team, and own rationale and knowledge. I also became aware that the frustration I was feeling was due to my judgement of my own indecisiveness, as a common self-criticism I have for myself is that I should be more decisive.

3.2.1.3. Abstract conceptualisation and active experimentation.

Becoming aware of the role of my people pleasing tendency, and how the situation was drawing out my self-criticism enabled me to understand and subsequently overcome this. I learnt to cope with this conflict by recognising that other people provide advice for me to consider, considering my rationale and challenging my self-criticism by reflecting on the good decisions I have made and my correct judgements in previous assignments. This enabled me to become more confident in my own opinion and rationale. I hope to be able to take this increased confidence and understanding forward into my search for a job, and my work as a qualified Clinical Psychologist.

3.2.2. “double-edged sword”

3.2.2.1. Concrete experience.

I experienced intrapersonal conflicts throughout my analysis for my systematic review, and within the interview process and analysis for my empirical study. Similar to the conflicts described by the nurses in my study, I experienced conflicts between my role as a researcher, and being a clinician and a person. As a researcher I felt

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responsibility to identify interesting and useful findings, by exploring the adolescents' and nurses' experiences in detail. However, as a person, I found reading the adolescents' accounts in the review and listening to the nurses' experiences emotive, and hard to sit with. Additionally, as a clinician, I felt a desire to be able to tolerate these emotional experiences, and validate the nurses and help them challenge and explore their self-critical thoughts. Furthermore, I felt conflicted, as I wanted to protect the nurses from experiencing any distress by avoiding challenging topics in the interviews, but also wanted to explore their experiences in-depth.

Moreover, similar to the "*rollercoaster of emotions*" described by the nurses in my empirical study, I was aware of going on my own "*rollercoaster of emotions*" throughout the process. At times I greatly enjoyed the process, and other times I felt stressed and overwhelmed. For example, I felt conflicted about the IPA and Thematic Synthesis approaches I used, as while I found the processes time consuming and felt anxious about doing a 'good enough' analysis, I found it extremely satisfying and rewarding when the themes came together and they felt interesting and useful.

3.2.2.2. Reflective observation.

Through reflexivity, I identified that I was at times being pulled into the rescuer role within Karpman's (1968) Drama Triangle, as I wanted to step in and help the nurses. This is a tendency that I am aware of and manage in my clinical practice, and was one of the reasons I chose not to interview adolescents about their experiences of self-harm, as I felt that I would likely fall into the Rescuer role and would have found it challenging not to provide therapeutic input. I also discovered that while I enjoyed the analysis, the responsibility I felt to ensure I identified interesting and useful findings

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increased the anxiety and pressure I experienced. For example, one of my reflective journal entries read, *“I feel like I need to include all of the themes as they are all important experiences”*.

Reflecting on these experiences enabled me to recognise how the clinician and person within me were useful for my role as a researcher. My personal responses enabled me to tune into what the nurses were feeling, and empathise with their experiences. Additionally, my skills as a clinician enabled me to build rapport with the nurses, and facilitate their exploration of their experiences.

3.2.2.3. Abstract conceptualisation and active experimentation.

I have learnt the benefit of recognising and utilising the different parts of myself within research. I plan to use this awareness in my future clinical work and research as a qualified Clinical Psychologist. For example, I will utilise more of my personal skills and self-awareness to recognise transference and counter-transference within clinical sessions and research interviews. This process has therefore enabled me to develop as a reflective and self-aware Clinical Psychologist, who is a researcher and a clinician. Additionally, my experiences of my own conflicts and hearing the conflicts experienced by the adolescents within my literature review, and the nurses within my empirical study encouraged a sense of acceptance and compassion within myself, which I hope to continue to build upon.

3.3. Personal and Professional Development

3.3.1. “I can switch off... from being a professional, and be a person”

3.3.1.1. Concrete experience.

Throughout the research process, I experienced and managed difficult emotions. For example, I initially felt guilt for having to exclude nurses working in Learning Disability CAMHS, as I felt that I was not giving them the opportunity for their voices to be heard. I managed this by considering my rationale and reassuring myself that a more homogenous sample was required for my research. Additionally, during the interviews, I felt a pressure to ask the ‘right’ questions, to ensure that I would be able to get an in-depth understanding of the nurses’ experiences. I managed this with compassionate self-talk, using the interview guide when needed, and allowing the nurses to guide the interview. Similarly, I found the process of generating the final themes challenging as I felt the need to include all of the emerging themes from the data. I managed this by accepting my limitations and the difficult thoughts I was experiencing, gaining advice from my research team, seeking reassurance from my cohort and validating myself. For example, in my reflective journal I wrote, “*I’m reminding myself that I am an IPA novice, and that this is a challenging process for any trainee*”.

3.3.1.2. Reflective observation.

Reflecting on these experiences I identified that I had been putting pressure on myself to do the ‘perfect’ interview and analysis as I felt responsible for ensuring that the nurses’ experiences were accurately reported in a meaningful way that could be disseminated and useful for the nurses who had invested their time and selves into my research. I became aware that this paralleled the responsibility and high expectations

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that the nurses appeared to have for themselves when working with adolescents who self-harm. Reflecting on previous situations where I have felt similar, I identified that this feeling often appears when I am new to a role, such as starting new placements during the doctorate, as I feel like I need to fulfil the role perfectly, to be ‘good enough’ for the people I am working with.

Reflecting on the ways I had tolerated the feelings I had experienced, I again recognised a similarity with the nurses’ experiences of accepting their limitations, validating themselves, and gaining validation and reassurance from others. These techniques reminded me of the Compassion Focussed Therapy (CFT) therapeutic model that I often use when working with clients clinically (Gilbert, 2009).

3.3.1.3. Abstract conceptualisation and active experimentation.

This experience and reflection has enabled me to become aware that I will likely have high expectations of myself as a newly qualified Clinical Psychologist. I therefore intend to use reflective practice and CFT approaches to manage my expectations and build my soothing system. I will also consider the appropriateness of considering CFT when supervising CAMHS nurses. Additionally, reflecting on the high expectations I have for myself, and hearing how the nurses have managed this through gaining confidence and growing as a clinician, I have learnt that my skills and confidence will grow through experience as a qualified Psychologist. Reminding myself of this will likely make it easier for me to tolerate the initial anxiety and self-doubt I will experience when I transition into being a qualified Clinical Psychologist.

3.3.2. “it has got easier, just with experience”

3.3.2.1. Concrete experience.

With regards to my development, I have noticed my understanding of IPA and Thematic Synthesis, and my confidence as a researcher increase through the whole process. Paralleling what the nurses described, my initial feelings of anxiety and self-doubt during the interview process and analysis decreased as I gained experience and understanding. I also developed my understanding and confidence in working with adolescents who self-harm. Furthermore, as described in the sections above, I experienced personal and professional growth, with regards to gaining more understanding of myself as a person, a researcher and a clinician.

3.3.2.2. Reflective observation.

Upon reflection, I identified that my initial anxiety about research was due to a lack of experience as a qualitative researcher. However, as the research progressed, I identified that my clinical skills were highly transferable to the role of a qualitative researcher. This led me to reflect on the conceptualisation of Clinical Psychologists as ‘reflective scientist practitioners’, and how we are well suited to conduct research to produce practice-based evidence, and enhance evidence-based practice. Moreover, my anxiety was likely increased due to my previous experience of finding positivist, quantitative approaches challenging, and less personally meaningful and interesting, due to their incongruence with my interpretivist epistemological position.

Reflecting on my increased understanding and confidence in managing adolescents self-harm, I recalled times that I have worked with adolescents who self-

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harm, and the anxiety I experienced due to feeling unsure of how to understand and manage it. This again demonstrated how my experience paralleled the nurses' experiences.

3.3.2.3. Abstract conceptualisation and active experimentation.

Overall, the experience has helped me become a more well-rounded Clinical Psychologist, as while I previously saw myself as more of a clinician, I now see myself as both a clinician and a researcher, and hope to continue to utilise and develop both of these skill sets. As a researcher, I have gained skills and confidence, and have learnt that I find qualitative, interpretative research interesting and useful. I have also enjoyed being more of an autonomous learner, whilst working within and liaising with a research team. I will therefore look for opportunities to conduct more qualitative research in the future. With regards to my growth as a clinician, I have gained more insight into the experiences of adolescents who self-harm, and therefore gained more understanding of the reasons why adolescents may self-harm, and the ways that I can work with them to manage these. I have also gained insight into the difficulties faced by nurses, and the kinds of support that they might benefit from. I greatly enjoy providing supervision as part of my role as a trainee. As a qualified Clinical Psychologist, I will therefore seek opportunities to supervise CAMHS nurses, to use the knowledge and skills I have gained to support them, and continue to develop myself. This experience will subsequently enhance my future clinical work with adolescents who self-harm, and my supervision of CAMHS nurses. My increased understanding of the research process will also enhance my critical analysis of clinical research in the future. Furthermore, as a person, I have gained more self-awareness, resilience and confidence in my opinion and ability, which I hope to take forward and continue to develop.

3.4. Compassion Focussed Therapy (CFT)

Whilst conducting my empirical study, I conceptualised the nurses' experiences of personal and professional conflicts, and subsequently my own experiences of the research process, within the three basic human emotion regulation systems in Gilbert's (2009) CFT model (see figure 3.2): The threat system (protection and safety seeking), the drive system (incentive-focussed), and the soothing system (affiliation-focused, connectedness).

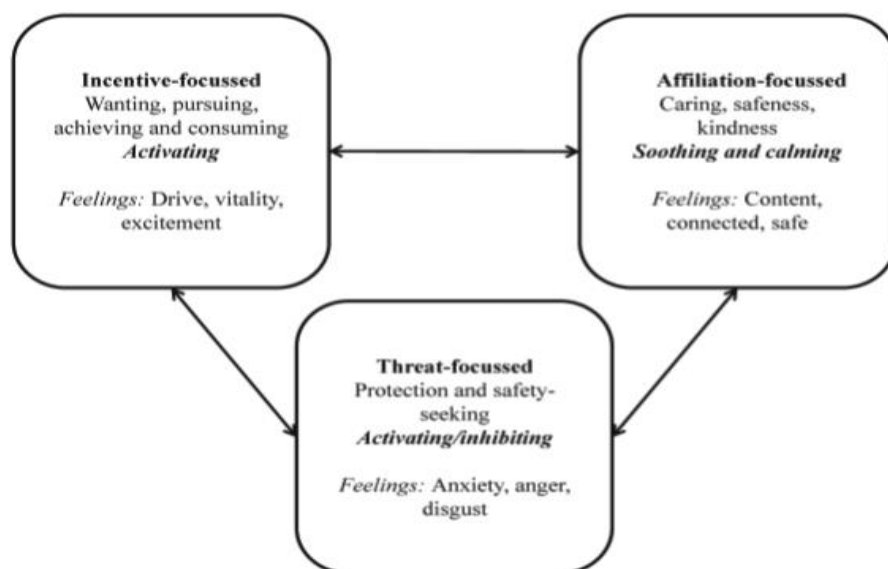


Figure 3.2. The human emotional systems (Dale-Hewitt & Irons, 2015).

I understood the anxiety and frustration (threat-based emotions) experienced by the nurses as a consequence of the threat system, and their subsequent aims to protect the adolescents, and themselves from professional judgment (Gilbert & Irons, 2015). Similarly, I understood my own anxiety and frustration as due to a perceived threat of professional judgement and failing my doctorate. Whilst individuals can perceive such

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responses as unhelpful or a sign of weakness, CFT advocates the importance of understanding and attending to our natural responses and not dismissing them.

Moreover, the pressures of the health service and professional demands may have lead the nurses to utilise their drive system to manage their sense of threat and take action by working hard for the adolescents and their systems. This appeared to be a successful strategy for the nurses who subsequently experienced a sense of pride and reward, which enabled them to continue enjoying their jobs despite the distressing elements of it. Similarly, I managed my sense of threat by actively recruiting nurses as early as possible, to give myself time to do a ‘good’ analysis, and hopefully achieve my goals of conducting interesting, useful and publishable research. Additionally, the nurses’ soothing systems were activated to manage the threat-based emotions they experienced, through connecting with colleagues, seeking support, sharing jokes and having a shared language only understood by those in the same role. I also activated my soothing system using compassionate self-talk, and by gaining advice and reassurance from my research team and cohort.

Furthermore, CFT advocates the importance of a balance of all three emotional regulation systems. The nurses appeared to initially experience their threat and drive systems as most dominant, with high levels of anxiety, and a desire to work more. While their soothing systems appeared to develop overtime, many of them described continuing to experience high levels of anxiety and struggling to “switch off”. Consistent with this, when I initially began the research process, I felt that my threat and drive systems were most dominant, however, by acknowledging this, I was able to attend to them, and prioritise self-care. This made the process more enjoyable and less

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anxiety inducing. It may therefore be useful for the nurses to be encouraged to acknowledge and attend to their threat, and drive systems. They should also be given time to build their soothing systems by connecting with their team and engaging in self-care strategies, including regular breaks, a protected work-life balance and supportive supervision. Overall, I hope to use this understanding and balance to manage future challenges in my role as a Clinical Psychologist and enhance support for CAMHS nurses.

3.5. Conclusion

Prior to completing this research, I was aware that reflexivity and self-awareness are recommended as vital within the qualitative research process. Conducting this research enabled me to understand the true meaning of reflexivity, and that I am an important part of the qualitative research process. My reflexivity during the process (reflecting-in-action) and my retrospective reflection (reflection-on-action) writing this chapter has led to personal and professional development for me, as a clinician, a researcher and a person. Being in the final year of my doctorate has led me to begin to think about my transition into being a qualified Clinical Psychologist, and the challenges I may face. I therefore intend to take this development into my career as a qualified Clinical Psychologist. I am hopeful that participants may have experienced a similar sense of empowerment and learning through the process of talking about their experiences, and having their voices heard.

3.5. References

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Appendix A

Child and Adolescent Mental Health Journal Author Guidelines

Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice; Narrative Matters.

Manuscripts should be submitted online.

Review Articles

Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the PRISMA statement. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice. Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

Recommended guidelines and standards

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the PRISMA Statement. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis. The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow.

Manuscripts should be double-spaced and conform to the house style of CAMH. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Summary: *Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.*

Key Practitioner Message: *Below the Abstract, please provide 1-2 bullet points answering each of the following questions:*

• *What is known? - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.*

- *What is new? - What does your study tell us that we didn't already know or is novel regarding its design?*
- *What is significant for clinical practice? - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?*

Keywords: *Please provide 4-6 keywords use MeSH Browser for suggestions*

Headings: *Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.*

Referencing: *CAMH follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.*

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

Tables: *These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.*

Figures: *Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See <http://authorservices.wiley.com/bauthor/illustration.asp> for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.*

Appendix B

Certificate of Ethical Approval from The University of Coventry for Chapter One Systematic Review



Certificate of Ethical Approval

Applicant:

Gemma Leddie

Project Title:

A Systematic Review of Experience's of Self-harm in Adolescence.

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

20 April 2018

Project Reference Number:

P70008

Appendix C

Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist

Criteria	Klineberg, Kelly, Stansfeld & Bhui, 2013	Harvey & Brown, 2012	Bheamadu, Fritz, & Pillay, 2012	Lesniak, 2010	McAndrew & Warne, 2014	Crouch & Wright, 2004
Was there a clear statement of the aims of the research?	2	1	2	2	2	2
Is a qualitative methodology appropriate?	2	2	2	2	2	2
Was the research design appropriate to address the aims of the research?	1	1	1	2	2	2
Was the recruitment strategy appropriate to the aims of the research?	2	2	1	1	1	2
Was the data collected in a way that addressed the research issue?	2	1	2	2	2	2
Has the relationship between researcher and participants been adequately considered?	1	1	0	2	1	1
Have ethical issues been taken into consideration?	2	1	1	1	2	2
Was the data analysis sufficiently rigorous?	1	1	1	2	2	2
Is there a clear statement of findings?	2	2	2	2	2	2
How valuable is the research?	2	1	1	2	2	2
Total	17	13	13	18	18	19

Criteria	Mitten, Preyde, Lewis, Vanderkooy & Heintzman, 2016	Moyer & Nelson, 2007	Rissanen, Kylma & Laukkanen, 2008	Rissanen, Kylma & Laukkanen, 2009	Wadman et al., 2017a	Wadman et al., 2017b
Was there a clear statement of the aims of the research?	2	2	2	2	2	2
Is a qualitative methodology appropriate?	2	2	2	2	2	2
Was the research design appropriate to address the aims of the research?	2	2	2	2	2	1
Was the recruitment strategy appropriate to the aims of the research?	2	2	2	2	2	2
Was the data collected in a way that addressed the research issue?	2	2	1	2	2	2
Has the relationship between researcher and participants been adequately considered?	1	2	0	1	2	2
Have ethical issues been taken into consideration?	1	1	1	1	2	2
Was the data analysis sufficiently rigorous?	1	1	2	2	2	2
Is there a clear statement of findings?	2	2	2	1	2	2
How valuable is the research?	2	1	1	2	2	2
Total	17	17	15	17	20	19

Appendix D

Inter-Rater Reliability Coefficient (Kappa) Outputs for All Papers Reviewed

Paper 1: Klineberg, Kelly, Stansfeld & Bhui, 2013

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	.783	.201	2.535	.011
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 2: Harvey & Brown, 2012

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	.737	.241	2.415	.016
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 3: Bheamadu, Fritz, & Pillay, 2012

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	1.000	.000	3.943	.000
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 4: Lesniak, 2010

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	1.000	.000	3.162	.002
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 5: McAndrew & Warne, 2014

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	.615	.337	2.108	.035
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 6: Crouch & Wright 2004

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	1.000	.000	3.162	.002
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 7: Mitten, Preyde, Lewis, Vanderkooy & Heintzman, 2016

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	1.000	.000	3.162	.002
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 8: Moyer & Nelson, 2007

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	1.000	.000	3.162	.002
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 9: Rissanen, Kylma & Laukkanen, 2008

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	.804	.186	3.324	.001
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 10: Rissanen, Kylma & Laukkanen, 2009

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	.737	.241	2.415	.016
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 11: Wadman et al. 2017a

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	1.000	.000	3.162	.002
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Paper 12: Wadman et al. 2017b

Symmetric Measures

	Value	Asymptotic Standard Error ^a	Approximate T ^b	Approximate Significance
Measure of Agreement Kappa	.615	.337	2.108	.035
N of Valid Cases	10			

a Not assuming the null hypothesis.

b Using the asymptotic standard error assuming the null hypothesis.

Appendix E

The Enhancing Transparency in Reporting the Synthesis of Qualitative Research

(ENTREQ) Statement (Tong et al., 2012)

No	Item	Guide and description
1	Aim	State the research question the synthesis addresses.
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (<i>e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis</i>).
3	Approach to searching	Indicate whether the search was pre-planned (<i>comprehensive search strategies to seek all available studies</i>) or iterative (<i>to seek all available concepts until they theoretical saturation is achieved</i>).
4	Inclusion criteria	Specify the inclusion/exclusion criteria (<i>e.g. in terms of population, language, year limits, type of publication, study type</i>).
5	Data sources	Describe the information sources used (<i>e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists</i>) and when the searches conducted; provide the rationale for using the data sources.
6	Electronic Search strategy	Describe the literature search (<i>e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits</i>).
7	Study screening methods	Describe the process of study screening and sifting (<i>e.g. title, abstract and full text review, number of independent reviewers who screened studies</i>).
8	Study characteristics	Present the characteristics of the included studies (<i>e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions</i>).
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion (<i>e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development</i>).
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (<i>e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings</i>).
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (<i>e.g. Existing tools: CASP, QARI, COREQ; reviewer developed tools; describe the domains</i>).

		<i>assessed: research team, study design, data analysis and interpretations, reporting).</i>
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (<i>e.g. all text under the headings “results /conclusions” were extracted electronically and entered into a computer software</i>).
15	Software	State the computer software used, if any.
16	Number of reviewers	Identify who was involved in coding and analysis.
17	Coding	Describe the process for coding of data (<i>e.g. line by line coding to search for concepts</i>).
18	Study comparison	Describe how were comparisons made within and across studies (<i>e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary</i>).
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author’s interpretation.
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (<i>e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct</i>).

Appendix F

Author Guidelines for the Journal of Clinical Nursing

AIMS AND SCOPE

The Journal of Clinical Nursing (JCN) is an international, peer reviewed, scientific journal that seeks to promote the development and exchange of knowledge that is directly relevant to all spheres of nursing practice. The primary aim is to promote a high standard of clinically related scholarship which advances and supports the practice and discipline of nursing. The Journal also aims to promote the international exchange of ideas and experience that draws from the different cultures in which practice takes place. Further, JCN seeks to enrich insight into clinical need and the implications for nursing intervention and models of service delivery. Emphasis is placed on promoting critical debate on the art and science of nursing practice.

JCN is essential reading for anyone involved in nursing practice, whether clinicians, researchers, educators, managers, policy makers, or students. The development of clinical practice and the changing patterns of inter-professional working are also central to JCN's scope of interest. Contributions are welcomed from other health professionals on issues that have a direct impact on nursing practice.

MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles

Word limit: 8,000 words maximum (quotations are included in the overall word count of articles, and abstract, references, tables and figures are excluded).

Abstract: 300 words maximum, and structured under the sub-headings: Aims and objectives; Background (stating what is already known about this topic); Design; Methods (for both qualitative and quantitative studies state n); Results (do not report p values, confidence intervals and other statistical parameters); Conclusions (stating what this study adds to the topic); Relevance to clinical practice.

Main text structure: Introduction (putting the paper in context - policy, practice or research); Background (literature); Methods (design, data collection and analysis); Results; Discussion; Conclusion; Relevance to clinical practice.

Impact Statement: should contain 2-3 bullet points under the heading 'What does this paper contribute to the wider global clinical community?'

Parts of the Manuscript

Title Page: The title page should be submitted separately to the main file and contain: i. A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips). ii. A short running title of less than 40 characters. iii. The full names of the authors. iv. The authors' institutional affiliations at which the work was carried out. v. Corresponding author's contact email address and telephone number. vi. Acknowledgements. vii. Conflict of Interest Statement. viii. Funding or sources of support in the form of grants, equipment, drugs etc. The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

Main Text File and Figures: The main text file should be presented in the following order:

i. Title, abstract and key words; ii. Main text; iii. References; iv. Tables (each table complete with title and footnotes); v. Figure legends; vi. Appendices (if relevant).

Title The title must contain both a descriptive and concise title of the paper. Country names are only to be included in titles where it is made clear the content is being compared and contrasted to the International arena.

Keywords Please provide up to 10 keywords. When selecting keywords, Authors should consider how readers will search for their articles. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at <https://www.nlm.nih.gov/mesh/>.

Main Text: As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. All articles must be relevant to an international audience. Authors should explain policies, practices and terms that are specific to a particular country or region; outline the relevance of the paper to the subject field internationally and also its transferability into other care settings, cultures or nursing specialities; placed discussions within an international context any papers exploring focussed cultural or other specific issues, and that clinical issues are put into context to other geographical regions and cultural settings. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References: APA Style. References should be prepared according to the Wiley APA Manual Style.

Tables: Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends: Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures: Although we encourage authors to send us the highest-quality figures possible, for peer-review purposes we are happy to accept a wide variety of formats, sizes, and resolutions.

Figures submitted in colour will be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white.

Appendices: Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

General Style Points: The following points provide general advice on formatting and style.

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Appendix G

Participant Information Sheet



Participant Information Sheet

Research Title: What are Community CAMHS nurses' experiences of working with adolescents who self-harm?

Researcher: Gemma Leddie

Invitation

Thank you for showing interest in taking part in this study. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. This information sheet will explain more about this research project and what it will involve if you decide to take part. Please feel free to ask if there is anything you would like explained further, or if you have any questions.

What is the purpose of this study?

The aim of this study is to explore CAMHS nurses' experiences of working with adolescents who self-harm in the community. The term 'Self-harm' refers to any act of self-poisoning or self-injury carried out by an individual irrespective of (his or her) motivation. The researcher is interested in hearing about your experiences of working with these young people. A number of nurses who work in CAMHS will be interviewed. It is hoped that this will lead to a better understanding of nurse's experiences and enable appropriate forms of support and education to be created.

Why have I been chosen?

For the purposes of the study the researcher needs to recruit a sample of qualified nurses who are working in West Midlands CAMHS. The researcher would like to talk to nurses who have worked with an adolescent who has self-harmed in the last 12 months, regardless of their length of experience with these young people. The person who gave you this information sheet thinks that you might fit this description. As a result it is deemed important that your viewpoint and experiences be captured for this research.

What will happen to me if I take part?

You will be asked to meet the researcher for a short one-to-one interview, during which they will ask you questions about your experiences of working with adolescents who self-harm. The interview will be quite open ended to allow you to freely talk about your experiences and any effects these experiences may have had on you. Before the interview you will be asked to consent to taking part in the study and being audio recorded. You will also be given an opportunity to ask any questions. Following the interview, fifteen minutes is allocated for you to unwind before returning to work. It is therefore anticipated that the whole meeting will take approximately an hour.

The interview will be completed in a private room, somewhere that is convenient for you, most likely your place of work. You will be allowed to take a break whenever you would like and refreshments will be available. With your consent, the interview will be audio recorded. This recording will be transcribed, anonymised (using pseudonyms) and deleted by

the researcher. Only the researcher (Gemma Leddie, Trainee Psychologist) and the researcher's academic supervisors (Dr Sarah Simmonds, Clinical Psychologist; Dr Claudine Fox, Programme Director, MSc in Clinical Applications of Psychology) will have access to these anonymised transcripts. You will also be given the opportunity to review the results via email once all interviews have been completed.

How long do I have to decide if I would like to take part?

You have a week to decide if you would like to take part in this study. If you would like to take part in the study, please complete the response slip at the end of this information sheet and return it to the researcher (Gemma Leddie).

Do I have to take part and can I withdraw?

No, you do not have to agree to take part in the study. Participation is entirely voluntary and there will be no consequences if you do not take part.

Yes you can withdraw. If you agree to take part in the study, and then change your mind, you can withdraw at any point during the interview and at any time up to four weeks after the interview session, without giving a reason. There are no consequences to deciding that you no longer wish to participate in the study. You can withdraw by contacting the researcher via email and providing them with your participant information number. If you decide to withdraw within four weeks after your interview all of your data will be destroyed and will not be used in the study. If you withdraw following this date, it will not be possible to withdraw the data you have provided.

What are the possible disadvantages or risks associated with this project?

Although it is not anticipated that the study will cause you any harm, it is possible that talking about sensitive issues such as self-harm may be distressing for you, and may bring up some difficult emotions. You may also feel uncomfortable talking about some of your experiences. If the discussion becomes difficult you will be able to stop the meeting at any time. You will also be able to ask any questions once it has finished. If for any reason you feel upset by the meeting and would like further support please let the researcher know and she will organise support in the first instance.

Who do I contact if I wish to make a complaint on any issue?

If you have a concern about any aspect of this study then please contact Gemma Leddie via email (leddieg@uni.coventry.ac.uk), who will try to answer your questions. In the unlikely eventuality that the researcher has to cancel the interview she will attempt to contact you via email as soon as possible.

If you have any complaints please speak to the research team in the first instance. If you require further assistance or if there are any problems not resolved by the research team, please contact:

Name: Andrew King

Email: hsx471@coventry.ac.uk

Address: University Applied Research Committee, Coventry University, Priory Street, Coventry, CV1 5FB

What are the benefits of taking part?

The experience may be cathartic for you, as research has shown that participants often benefit from the experience of being listened to. This is an opportunity for your voice to be heard. It is hoped that the study will be used to increase understanding of community CAMHS nurses' experiences, and therefore shape and inform future research and support process for yourself and other CAMHS nurses.

Will my taking part in this study be kept confidential?

Yes. All information collected about you will be kept strictly confidential, and only the research team will have access to this information. The audio recordings will be destroyed once they are transcribed and transcripts will be password protected. You will only be identified on the interview transcript by your participant code number. Only the lead researcher and their research supervisors will have access to the transcripts, clinical supervisors who work in the services will not have access to these. No confidential information will be used in the report, although anonymised quotes will be used to demonstrate the findings.

However, should you disclose any information during the interview that the researcher believes might put you or another person at risk, the researcher will be obliged to inform their clinical supervisor. The clinical supervisor will then escalate this if required.

What will happen to the information I provide and the results of the study?

The information you provide during the interview will be transcribed into written form, after which the recording will be erased. Consistent with university policy, the anonymised transcripts will be stored in a locked cabinet on Coventry University premises for 5 years, after which they will be destroyed. The consent forms will be stored separate in a secure (locked) cabinet on Coventry University premises for 5 years.

The results of this study will be used by the primary researcher, Gemma Leddie, as part of the academic requirement of the Coventry and Warwick Doctoral Course in Clinical Psychology. The results will be written up and presented as part of the researcher's (Gemma Leddie) Doctoral Thesis. The results of this study may be written up for publication in psychology and/or other mental health journals and/or presented at academic conferences. A summary of the results will be made available to all participants, and service managers. You will not be personally identified in these reports.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, in order to protect your safety, rights, wellbeing and dignity. This study has been reviewed and approved by the Coventry University Research Ethics Committee, and the NHS ethics committee (the Integrated Research Application System).

Who is organising and funding the research?

The study is being organised as part of Gemma Leddie's Clinical Psychology Doctoral Course at the Coventry and Warwick Universities. No payment is being received by any of the organisers for conducting this study.

Who can I contact for further information?

If you have any questions about this study or would like to withdraw, feel free to contact us:

Gemma Leddie;	Dr Sarah Simmonds;
Clinical Psychology Doctorate Programme	Clinical Psychology Doctorate Programme
Universities of Coventry & Warwick	Universities of Coventry & Warwick
Coventry University	Coventry University
James Starley Building	James Starley Building
Priory Street	Priory Street
Coventry	Coventry
CV1 5FB	CV1 5FB
leddieg@uni.coventry.ac.uk	sarah.simmonds@coventry.ac.uk

Thank you

Thank you for taking the time to read this information sheet. I hope that this information is helpful and reassuring. If you would like to take part in the study, please complete the response slip below and return it to the researcher. Only a certain number of interviews can be conducted, therefore interviews will take place on a first come first served basis until the necessary number of interviews have taken place. Upon receipt of the response slip the researcher will contact you to either arrange a suitable time for the interview, or thank you for your interest but inform you that all interviews have already taken place.

----- **Response slip**

Name.....

Job Role

I would like to take part in the above study am happy to be contacted to arrange a date and time of interview. Please contact me on

.....(email/phone)

Appendix H

Coventry University Ethical Approval for Chapter Two Empirical Paper



Certificate of Ethical Approval

Applicant:

Gemma Leddie

Project Title:

What are community CAMHS nurses' experiences of working with adolescents who self-harm?

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as High Risk

Date of approval:

10 February 2018

Project Reference Number:

P62414

Appendix I

HRA Ethical Approval



Health Research Authority

Miss Gemma Leddie
Clinical Psychology Doctorate, School of Psychological,
Social and Behavioural Sciences
Coventry University, James Starley Building
Priory Street, Coventry
CV1 5FB

Email: hra.approval@nhs.net

21 March 2018

Dear Miss Leddie

Letter of HRA Approval

Study title:	What are community CAMHS nurses' experiences of working with adolescents who self-harm?
IRAS project ID:	239035
REC reference:	18/HRA/1549
Sponsor	Coventry University

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further from the HRA.

How should I continue to work with participating NHS organisations in England?

You should now provide a copy of this letter to all participating NHS organisations in England, as well as any documentation that has been updated as a result of the assessment.

The HRA has determined that participating NHS organisations in England **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the [local information pack](#) for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the [NHS RD Forum website](#) and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: **Spring24**). The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA Approval. Further information is provided in the “*summary of HRA assessment*” section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

How should I work with participating NHS/HSC organisations in Northern Ireland, Scotland and Wales?

HRA Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland, Scotland and Wales.

If you indicated in your IRAS form that you do have participating organisations in one or more devolved administration, the HRA has sent the final document set and the study wide governance report (including this letter) to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with Northern Ireland, Scotland and Wales.

How should I work with participating non-NHS organisations?

HRA Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document “*After HRA Approval – guidance for sponsors and investigators*” gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Dr Sarah Simmonds
E-mail aa8439@coventry.ac.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

IRAS project ID	239035
-----------------	--------

Your IRAS project ID is **239035**. Please quote this on all correspondence.

Yours sincerely

Catherine Adams

Senior Assessor

Email: hra.approval@nhs.net

*Copy to: Dr Sarah Simmonds, Sponsor's Representative
Miss Wright Kay, Coventry & Warwickshire Partnership NHS Trust*

Appendix J

Participant Information Sheet



Participant Information Sheet

Research Title: What are Community CAMHS nurses' experiences of working with adolescents who self-harm?

Researcher: Gemma Leddie

Invitation

Thank you for showing interest in taking part in this study. Before you decide, it is important for you to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. This information sheet will explain more about this research project and what it will involve if you decide to take part. Please feel free to ask if there is anything you would like explained further, or if you have any questions.

What is the purpose of this study?

The aim of this study is to explore CAMHS nurses' experiences of working with adolescents who self-harm in the community. The term 'Self-harm' refers to any act of self-poisoning or self-injury carried out by an individual irrespective of (his or her) motivation. The researcher is interested in hearing about your experiences of working with these young people. A number of nurses who work in CAMHS will be interviewed. It is hoped that this will lead to a better understanding of nurse's experiences and enable appropriate forms of support and education to be created.

Why have I been chosen?

For the purposes of the study the researcher needs to recruit a sample of qualified nurses who are working in West Midlands CAMHS. The researcher would like to talk to nurses who have worked with an adolescent who has self-harmed in the last 12 months, regardless of their length of experience with these young people. The person who gave you this information sheet thinks that you might fit this description. As a result it is deemed important that your viewpoint and experiences be captured for this research.

What will happen to me if I take part?

You will be asked to meet the researcher for a short one-to-one interview, during which they will ask you questions about your experiences of working with adolescents who self-harm. The interview will be quite open ended to allow you to freely talk about your experiences and any effects these experiences may have had on you. Before the interview you will be asked to consent to taking part in the study and being audio recorded. You will also be given an opportunity to ask any questions. Following the interview, fifteen minutes is allocated for you to unwind before returning to work. It is therefore anticipated that the whole meeting will take approximately an hour.

The interview will be completed in a private room, somewhere that is convenient for you, most likely your place of work. You will be allowed to take a break whenever you would like and refreshments will be available. With your consent, the interview will be audio recorded. This recording will be transcribed, anonymised (using pseudonyms) and deleted by

the researcher. Only the researcher (Gemma Leddie, Trainee Psychologist) and the researcher's academic supervisors (Dr Sarah Simmonds, Clinical Psychologist; Dr Claudine Fox, Programme Director, MSc in Clinical Applications of Psychology) will have access to these anonymised transcripts. You will also be given the opportunity to review the results via email once all interviews have been completed.

How long do I have to decide if I would like to take part?

You have a week to decide if you would like to take part in this study. If you would like to take part in the study, please complete the response slip at the end of this information sheet and return it to the researcher (Gemma Leddie).

Do I have to take part and can I withdraw?

No, you do not have to agree to take part in the study. Participation is entirely voluntary and there will be no consequences if you do not take part.

Yes you can withdraw. If you agree to take part in the study, and then change your mind, you can withdraw at any point during the interview and at any time up to four weeks after the interview session, without giving a reason. There are no consequences to deciding that you no longer wish to participate in the study. You can withdraw by contacting the researcher via email and providing them with your participant information number. If you decide to withdraw within four weeks after your interview all of your data will be destroyed and will not be used in the study. If you withdraw following this date, it will not be possible to withdraw the data you have provided.

What are the possible disadvantages or risks associated with this project?

Although it is not anticipated that the study will cause you any harm, it is possible that talking about sensitive issues such as self-harm may be distressing for you, and may bring up some difficult emotions. You may also feel uncomfortable talking about some of your experiences. If the discussion becomes difficult you will be able to stop the meeting at any time. You will also be able to ask any questions once it has finished. If for any reason you feel upset by the meeting and would like further support please let the researcher know and she will organise support in the first instance.

Who do I contact if I wish to make a complaint on any issue?

If you have a concern about any aspect of this study then please contact Gemma Leddie via email (leddieg@uni.coventry.ac.uk), who will try to answer your questions. In the unlikely eventuality that the researcher has to cancel the interview she will attempt to contact you via email as soon as possible.

If you have any complaints please speak to the research team in the first instance. If you require further assistance or if there are any problems not resolved by the research team, please contact:

Name: Andrew King

Email: hsx471@coventry.ac.uk

Address: University Applied Research Committee, Coventry University, Priory Street, Coventry, CV1 5FB

Appendix K

Informed Consent form



Participant Consent Form

Participant Reference Code/ID number:.....

Research Title: What are community CAMHS nurses' experiences of working with adolescents who self-harm?

Researcher: Gemma Leddie

You will be asked to attend a one-to-one interview with the lead researcher (Gemma Leddie), of approximately one hour. With your permission, your interview will be audio recorded, and then transcribed so that a record of the interview can be stored. The written interview will be held on a password protected computer file. Names and other identifiable information will be changed to ensure anonymity and protect the identities of those taking part and those discussed. If you agree to take part in this interview, but feel at any stage that you would like to stop or that you do not want your comments used in the study, you are free to do so at any time, and your data will be destroyed.

Please initial

1. I confirm that I have read and understood the participant information sheet for the above study. I have had the opportunity to consider the information and feel able to make an informed decision about my participation.	
2. I understand that my participation is voluntary and that I am free to withdraw at anytime without giving a reason. I understand that I also have the right to change my mind about participating in the study for a short period after the study has concluded (four weeks), during which time all data can be removed from the study.	
3. I understand that all the information I provide will be treated in confidence and kept confidential. Nonetheless, I understand that should my information indicate a risk of immediate harm to myself or others, the researcher will be permitted to inform clinical management to inform them of this risk, and for support to be given.	
4. I understand that the study will be written up for a doctoral thesis, which may be published upon completion but that any information I provide will be anonymised for this.	
5. I agree to anonymised information and quotes from the interview to be included in a summary for team managers.	
6. I agree to be audio recorded and for anonymised quotes to be used as part of the research project.	
7. I would like the researcher to send me a summary of the main findings from the interviews and give me an opportunity to provide feedbacks.	
8. I agree to take part in the research project.	

Name of Participant:.....Signature:..... Date:.....

Name of Researcher:.....Signature:..... Date:.....

Appendix L

Participant Debrief



Debrief

Participant Reference Code/ID number:.....

Research Title: What are community CAMHS nurses' experiences of working with adolescents who self-harm?

Researcher: Gemma Leddie

Thank you very much for taking part in this interview. Your answers will be used to understand community CAMHS nurse's experiences of working with adolescents who self-harm. It is hoped that this information will be used to facilitate the creation of appropriate forms of support and education for nurses working with adolescents who self-harm in the community. The results of this study will be used by the primary researcher, Gemma Leddie, as part of the academic requirement of the Coventry and Warwick Doctoral Course in Clinical Psychology and will be written up and presented as part of the researcher's Doctoral Thesis. The results may also be written up for publication in psychology and/or other mental health journals and/or presented at academic conferences. A copy of the summary themes will be sent to the service manager, and can be sent to you if you would like.

Once again, we would like to assure you that all of your answers will be kept anonymous and no personal or identifiable information used in these reports. The recording of your interview will be transcribed and this anonymised transcription will be saved on a password protected computer file. We will change the name of any organisation and people involved to protect the identities of yourself and the people you work with. If you feel at any stage within the next four weeks that you do not want your comments to be used in the study, please contact one of the researchers using the details below within the next four weeks and your data will be destroyed. This will have no effect on your work.

Although it is not anticipated that the study will cause harm, we are aware that this experience may be upsetting or difficult for some participants. If you do experience any distress following the interviews, please be aware that there are a range of in-house and external, confidential services you can access. These include:

- Samaritans
- COPE
- MIND
- IAPT
- Jane Ralphs (lead nurse has agreed to provide in-house support for any CWPT participants).

Thank you again for taking the time to participate in this study. If you are concerned about any aspect of the study or have any questions, please contact one of the researchers (Gemma Leddie: leddieg@uni.coventry.ac.uk; Dr Sarah Simmonds: sarah.simmonds@coventry.ac.uk).

-----Response slip

Please provide your email address and give this response slip to Gemma Leddie if you would like to receive a summary of the results when the interviews have been analysed and written up. You will also be given the opportunity to reply to the email with feedback on the emerging themes, if you would wish.

Name..... Email address.....

Appendix M

Interview Schedule



Interview Schedule

Gemma Leddie

Introduction

Thank them for agreeing to be interviewed

Explain the use of digital recorder

Confidentiality arrangements (in confidence, anonymised reporting, can withdraw at any time)

Explain what the study is about (*interested in your personal experiences of working with adolescents who engage in self-harm, including your thoughts and feelings about self-harm and the impact this has had on you, and the support and coping strategies you have utilised*)

Inform participant that session will last for approximately 60 minutes, including a debrief at the end.

Ask them to complete consent forms with opportunity to ask questions

Confirm happy to proceed and be audio recorded

Introductory Questions

- *What is your date of birth and ethnicity?*
- *Can you tell me when you qualified as a nurse, and when you began working in CAMHS?*
- *In what settings have you worked with adolescents who self-harm?*
- *How long have you been working with adolescents who self-harm in the community?*

Experiences

- What is it like working with adolescents who self-harm?
- **Prompts:**
 - *How do you feel about working with clients who self-harm? (positive, negative, demanding, rewarding, difficult, emotional etc.)*
 - *Has it always felt like this for you?*
 - *How do you think working with self-harm affects you?*
 - *On a day-to-day basis how do you deal with the effects that you describe?*
 - *Prompt: What helps/gets in the way?*
 - *What are your feelings/views about the reasons why adolescents might self-harm?*
- If you have one, could you please describe a satisfying experience of working with a client who engaged in self-harming?
- **Prompts:**
 - *Can you tell me about how incidences like this affect you emotionally?*
 - *Did you experience any professional challenges? (influence of risk, policy, support, decision making)*
 - *Was there anything your colleagues did to make this a satisfying experience?*
- If you have one, could you please describe an unsatisfying experience of working with a client who engaged in self-harming?
- **Prompts:**
 - *Can you tell me about how incidences like this affect you emotionally?*

- *Did you experience any professional challenges? (influence of risk, policy, support, decision making)*
- *What strategies helped you cope with the experience?*
- *Is there anything other people did that helped you cope?*
- *Is there anything you do either in your professional or personal life that you feel helps you cope when working with those who self-harm or following an incident of self-harm?*

"Do you have any other thoughts or ideas about your experiences that I have not asked you about?"

Interview end

Thank participant for their participation

Debrief time (15 minutes allocated- questions, support and request summary)

Appendix N

Example Coding

Excerpt from John's transcript showing descriptive, linguistic and conceptual coding.

Comments identified descriptive codes and potential quotes; italicised comments highlighted conceptual codes and interesting language use.

Participant 1

1 **What is it like working with adolescents who self-harm?**

2 It's probably my favourite group, which is what most people won't say I am guessing [laugh]. I like the

3 challenge of adolescents anyway, It's remembering that the self-harm is about their trying to survive the

4 situation they are in. That's what it is, I think some people get caught up with 'their going to kill

5 themselves', no, it's about survival. Once you are used to it and you're into that way of thinking, it makes it

6 a bit more comfortable to work with.

7

8 **What makes it your favourite group to work with?**

9 I like teenagers anyway; I like the challenge of teenagers. I like to break down their pre-conceptions of my

10 self and people like me who sit in front of them with a nametag and all that sort of stuff and they don't think

11 you've lived a life. Ultimately, I do the job because I like people, and I think I have a bigger impact on

12 teenagers because their mental health difficulties are a bit more developed if you like, than when they were

13 younger, and the situation they are in is a lot more serious. And I can help with that, and to see the start to

14 cope better and not to need self-harm is great. Generally I tend to have the older teenagers as well, so to

15 actually see them go on to do something they have aspired to do and thought they couldn't do, that is why I

16 like to work with teenagers. The self-harm is a bit incidental, a lot of them are self-harming, and that's just

17 how it is unfortunately.

18

19 **What does it mean to you to be able to help these young people?**

20 For me, it means that I have helped them start to cope with things better, look at things differently and see

21 that there are different ways, other than cutting, because it is generally cutting I see, but self-harm full-stop.

22 So helping them see other ways to cope. But I would say I don't tackle the self-harm itself, it's more about

23 what are you struggling with? That is what we tackle, as the self-harm will fall away at that point. So again,

24 it is definitely, this sounds sad, but it is making the difference that is the big motivating aspect for me.

25

26 |

1

Gemma Leddie 22/2/2019 14:47

Comment [1]: Favourite group

Gemma Leddie 22/2/2019 14:48

Comment [2]: most people won't say I am guessing- feel unique for liking it, expect others not to like? Laugh?

Gemma Leddie 22/2/2019 14:48

Comment [3]: Like challenge of working with adolescents

Gemma Leddie 22/2/2019 14:50

Comment [4]: Helpful to understand self-harm as form of survival, some see it as wanting to kill themselves- understanding helps coping? See it as more positive? Other professionals don't understand/ get anxious?

Gemma Leddie 22/2/2019 14:53

Comment [5]: More comfortable when used to it+ understand

Gemma Leddie 22/2/2019 14:51

Comment [6]: Like challenge of working with adolescents

Gemma Leddie 22/2/2019 14:51

Comment [7]: Like breaking down teens preconceptions

Gemma Leddie 22/2/2019 14:52

Comment [8]: Meaningful job- job satisfaction/ purpose: Like people, bigger impact on teens than children as more severe

Gemma Leddie 22/2/2019 14:53

Comment [9]: "I can help with that"- pride, meaningfulness, hope

Gemma Leddie 22/2/2019 14:53

Comment [10]: Good to see progress- rewarding?

Gemma Leddie 22/2/2019 14:54

Comment [11]: Like to see them progress and do things aspired to do

Gemma Leddie 22/2/2019 14:54

Comment [12]: Self-harm incidental/ common in adolescents-not priority/ to be expected?

Gemma Leddie 22/2/2019 14:55

Comment [13]: Able to help them cope better+ stop SH

Gemma Leddie 22/2/2019 14:56

Comment [14]: Address underlying and SH falls away-SH not the focus

Gemma Leddie 22/2/2019 14:57

Comment [15]: "this sounds sad, but it is making the difference that is the big motivating aspect for me"- embarrassing to admit? Want to make a difference, motivating, passionate, hope

Participant 1

53

54 **Do you think your responses or the way you work with it has changed in anyway?**

55 After the first few years of not being used to it and settling into the technique I've developed of how I

56 approach the work with kids. No, I think I still work the same. In the first few years, it was scary, you just

57 wonder where this can go, and the last thing you want is them to really hurt themselves. Don't get me

58 wrong, I still don't want people to really hurt themselves, I don't know, the risk appears higher when you

59 first start working in the field, because you have nothing to base it on. Nothing in life prepares you for

60 working with self-harm.)

61

62 **Do you think working with self-harm affects you in anyway now?**

63 Not that I'm particularly aware of. Working in mental health I've got burnout definitely in some areas. I'm

64 thinking about when I first started in mental health, sitting with a man crying who was talking about wanting

65 to kill himself, and it felt surreal, I was thinking, how do I cope with it? What do I do? What is going to be

66 helpful and what is not? Whereas now, it's really sad to say, that it hardly ever touches me, because it's been

67 done so many times. I always say that I think there are pros and cons to this, because again, you don't have

68 that emotional response that means that people feel they have to rein in their own tears because they can see

69 you are becoming upset or whatever, but it's also quite sad that it doesn't do that to me anymore. But I'd

70 sooner be able to have that and cope with my job, as I do. I don't think it's because I ignore it, but there is a

71 worry aspect still to working with these young people. More the ones who are over dosing erm because what

72 surprised me over the years is people, teenagers and people in general, their lack of awareness of the danger

73 of overdosing. And they'll say things like "well its only paracetamol". I mean you can by a box for about 12

74 pence. So I think there is something about how as a society we are quick to take paracetamol and not think

75 about it and there is definitely a lack of awareness of the seriousness of over dosing as self-harm. So those

76 people still cause me considerable concern at times. Not all of them, it depends on the individual and how

77 they are seeing overdosing, but some are a little bit removed from reality shall we say, and they are the ones

78 that worry me. So yeah, there is some anxiety at times, but I hardly ever go home and think about them. If I

Gemma Leddle 22/2/2019 15:12

Comment [29]: First few years not used to it+ settle into technique- no confident in approach/ technique?

Gemma Leddle 22/2/2019 15:14

Comment [30]: Initially scary, worried about harm-previously more anxious, ruminate more

Gemma Leddle 22/2/2019 15:13

Comment [31]: "Don't get me wrong, I still don't want people to really hurt themselves"- worried about seeming not to care/ detached?

Gemma Leddle 22/2/2019 15:13

Comment [32]: Risk feels higher initially as no experience

Gemma Leddle 22/2/2019 15:14

Comment [33]: "Nothing in life prepares you for working with self-harm. "- *can't be prepared? Completely unique?*

Gemma Leddle 22/2/2019 15:33

Comment [34]: Not particularly aware of any effects

Gemma Leddle 22/2/2019 15:15

Comment [35]: "I've got burnout definitely in some areas"-very matter of fact/ normalizing/ detached?

Gemma Leddle 22/2/2019 15:16

Comment [36]: Clear memory of intensity/ emotional impact when first started- worrying, over thinking

Gemma Leddle 22/2/2019 15:16

Comment [37]: Now, used to it "hardly ever touches me"- less emotional impact. "sad to say"-guilt/ hard to admit detached/ less impacted

Gemma Leddle 22/2/2019 15:26

Comment [38]: Pros and cons to being detached- good not to be emotional, but sad that doesn't feel sad- want to be emotionally effected/ sad? others/ YPs needs more important?

Gemma Leddle 22/2/2019 15:25

Comment [39]: Rationalise detaching- would rather be able to cope+ do job- others/ YPs needs more important? Cope to help others?

Gemma Leddle 22/2/2019 15:27

Comment [40]: "I don't think its because I ignore it,"- *doubt/ unsure how cope/ why less anxious?*

Gemma Leddle 22/2/2019 15:30

Comment [41]: Still some worry

Gemma Leddle 22/2/2019 15:29

Comment [42]: Concern about YP who overdoses, lack awareness of danger, too easy to get medications

Gemma Leddle 22/2/2019 15:29

Comment [43]: Some anxiety, but generally don't take concerns home

Photos of Theme Clustering Process

